Urology Services Inquiry

Oral Hearing

Day 69 – Wednesday, 8th November 2023

Being heard before: **Ms Christine Smith KC (Chair)**

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

Gwen Malone Stenography Services

INDEX

THE INQUIRY RESUMED ON WEDNESDAY, 8TH NOVEMBER 2023, AS FOLLOWS

CHAIR: Good morning, everyone.

MR. WOLFE KC: Your witness this morning, Chair, is Mr. Michael Young, and he proposes to take the oath. 10:04

MR. MICHAEL YOUNG, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE, AS FOLLOWS

10:04

Q. MR. WOLFE KC: Good morning, Mr. Young.

A. Good morning.

1 Q. We'll start this morning by introducing or reintroducing you to the various statements that you have given, both to this Inquiry and to Dr. Chada's investigation. And at the end of that process, I'll ask you whether you wish to adopt those statements as part of your evidence to the Inquiry. So, there are several, probably more than most. 10:04

10:05

So, starting with your primary response to the Inquiry Section 21 process, if we go to WIT-51638, that is the first page. You can see that there's an annotation at the top indicating that we've received an amending statement from you in respect of this notice. 10:05

Then if we go to the last page, we can see that at WIT-51845 -- and do you recognise that as your first statement to the Inquiry?

A. I do.

2 Q. Subject to those amendments that I'll now bring you to, do you wish to adopt that statement as part of your evidence to the Inquiry?

A. I do. 10:06

3 Q. Thank you. Then the addendum to which I referred is dated 3rd November. It's WIT-104215 and we, as I say, received that from you on 3rd November, and I'll be bringing you in the course of your evidence to some of these amendments. 10:06

If we scroll down then to the end, it's five pages through, you recognise that as your signature?

A. I do.

4 Q. Again, do you wish to adopt that statement as part of your evidence? 10:07

A. Yes, please.

5 Q. Then a few days before this statement, we received a response to a second Section 21 notice which we had raised with you primarily to cover issues raised by Mr. Hagen in his evidence to the Inquiry, and we'll pull that up for you now. It's WIT-103604. You'll recognise the first page of that. I'll bring you to the last page then, and your signature -- it's at WIT-103621, as you can see there. Again, time-honoured question, do you wish to adopt that as part of your evidence to the Inquiry? 10:07 10:08

A. I do.

6 Q. Thank you. Then, finally, as part of this exercise,

your evidence to Dr. Chada, TRU-00751... Eh, we'll maybe come back to that if we can't bring it up --

A. That's okay, yeah.

7 Q. But you will recall that you sat with Dr. Chada and her support officer for the purposes of the MHPS investigation -- 10:09

A. Yes.

8 Q. And I understand those sittings were on 23rd March 2017 and 3rd April 2017, leading to the production of a statement which you then signed on 5th October 2017. Have you had an opportunity to review that statement in preparation for today? 10:09

A. Yes. Just the second date of the interview was --

9 Q. I understand it was 3rd April?

A. 3rd April, that's right. 10:09

10 Q. -- 2017. We can bring you to this statement later, if needed.

A. Yes.

11 Q. But are you happy to adopt the contents of that statement? 10:09

A. I am.

12 Q. Thank you. Now, we can see from your Section 21 statement, Mr. Young, that you qualified from Queen's University Belfast in 1983 and entered urological training after general surgical training, and that urological training commenced in 1992? 10:10

A. Correct.

13 Q. It took six years and you took up a consultant's post at what was to become the Southern Trust in or around

May 1998?

A. Correct.

14 Q. You stayed in that consultant's post, a consultancy in urology, from May 1998 through until May 2022 when you formally retired? 10:11

A. Yes.

15 Q. As of today, you continue a connection with the Southern Trust by acting as a part-time or locum consultant -- not locum --

A. No, no, I retired at the end of the May '22. I came back then as a part-time consultant working equivalent of four sessions a week. So that's a substantive but part-time post. 10:11

16 Q. One can see then, just looking at that time span, that you have had an association with -- just in simple terms, we call it the Southern Trust but the Inquiry is aware of the various changes in the structure of the Trust and its -- and that kind of thing over the years. But you've had a connection prior to your retirement of 24 years with the Southern Trust? 10:12

A. It's the same hospital, Craigavon Area Hospital all the way through, yes.

17 Q. Yes. That period of time in post hopefully allows you to cover quite a number of the issues which the Inquiry is interested in and, as part of your evidence, I hope you'll be able to explain to the Panel some of the early developments in the creation and development of the Urology Service, the difficulties that were faced into and may have lingered over the period. We'll also 10:12

wish to explore your role as a clinical lead and whether that had any particular importance, given the particular issues that the Inquiry is looking at in association with the practice of Mr. O'Brien, with whom you worked for a period of 22 years, and the governance arrangements around some of those issues.

So if we look to your witness statement at -- your first witness statement at WIT-51690. You set out, from paragraph 4.3 there, helpfully, your occupational history. As I've said, you took up a consultant's post in May 1998 at Craigavon, and the job description for that post is at TRU-101601.

As you explained, if we just scroll down to 5.4 -- thank you -- that you came into this post with, I suppose, a specialism in stone management; is that correct?

A. Correct.

18 Q. And as part of your work, the clinical part of your work involved general and specialist clinics, outpatient clinics, at Craigavon Area Hospital, Banbridge and Armagh, and then subsequently the South Western Acute Hospital; is that right?

A. Correct.

19 Q. In addition to that, you had day cases in theatre, both at Craigavon and the South Tyrone Hospital?

A. Correct.

20 Q. And inpatient operating took place primarily at the

Craigavon Hospital, but subsequently, particularly in light of the pandemic developments, in Daisy Hill Hospital in Newry?

A. Correct.

21 Q. Was there an oncology element to your clinical practice, or was it primarily a benign condition practice? 10:15

A. My practice was, from a general perspective, of all things relating to adult urology. It would have covered the benign contingent, but I did have an oncology interest. I had spent time at the Institute in London -- in Northern Ireland, we didn't have open surgery for prostate cancer -- and I spent some time there training in that specific type of surgery and brought that back home again. So I was exposed to quite a lot of open surgery from a bladder cancer point of view and from prostate cancer. 10:16 10:16

So I did have a broad oncology view of things and certainly for my first ten years in Craigavon doing open kidney surgery, open bladder surgery and doing radical prostatectomies was part of my field. 10:17

I obviously had an interest in stones, so that ran in tandem. And I ran our ESWL service throughout the whole period. 10:17

Certainly then after the review of 2009, all of the radical pelvic surgery went to Belfast. I still did

the open kidney surgery and I kept that going until more recent times when Mr. Haynes arrived. He had a particular interest in renal surgery, so I swapped my -- I got his stones and he got my kidneys, if you want to put it that way! 10:18

So in more recent times, my oncology interest certainly has waned to allow me to focus on the stone side. And, certainly from an oncology MDT point of view, I was at the meetings when they were being set up, but due to 10:19 the number of clinics that I was trying to cover, I did a Thursday afternoon Outpatients and dropped my MDT attachment to that in 2015.

22 Q. Yes. I think that's the helpful point I was going to bring you to. We can see that from the annual reports 10:19 associated with the MDT that you had very regular attendance from the establishment of the MDT I think in or about 2010?

A. Yes.

23 Q. Then looking at the report for 2015/2016, your 10:19 attendance at MDT dropped to 14 meetings out of 42, which isn't to suggest that you were a poor attender, it probably suggests that it was around that point in time when, as the number of consultants expanded, they took on the MDT role; is that fair? 10:20

A. That's fair. I think I had a lot of other commitments. I didn't have a new patient clinic slot. So that's what was then my Thursday afternoon.

24 Q. Just for the Panel's note, that Annual Report for 2015/

2016 showing 14 out of 42 meetings attended is to be found at AOB-77912.

You also make the point that, perhaps self-evidently, in association with the consultant's role, there is a comprehensive suite of administrative duties to perform, and you set that out at paragraph 5.8, if we just scroll down, and we'll come in due course to touch upon the impact of administration or the potential impact of administration and the growing need for administration as it developed through your career, how it may have impacted on other priorities. 10:21 10:21

You were also, as you explain at 5.12, just scrolling down again, you were also cast in the role as an appraiser of colleagues' work, the appraisal system coming into play around about 2010 or so. And we can see that you were an appraiser for, amongst others, Mr. O'Brien, for a period of five years, approximately, isn't that right? 10:21 10:22

A. The appraisal would have covered that five years, yeah.

Q. And we'll come in due course to look at the role that appraisal played and the approach that you adopted to it. 10:22

You declare or you notify us through your statement that one of your interests in association with urology was as a director of the charitable company CURE, isn't that right?

A. Correct.
26 Q. How long were you associated with CURE?
A. Well, I've attended the CURE events and everything to do with this over my tenure. I was then asked to become a director at some stage. I don't know exactly the date, but it would have covered 15 plus years. 10:23
27 Q. Would you have encountered Mrs. Brownlee through the CURE company and through your duties on CURE?
A. My duties, no, but I was aware that she was a founder member and would attend the social events. But as far as interaction specifically to do with CURE, no. 10:24
28 Q. The Inquiry has received evidence that Mr. O'Brien had a relationship, a patient-clinician relationship with Mrs. Brownlee, but was also in a position of friendship with her, and certain suggestions have been made about Mrs. Brownlee intervening on behalf of Mr. O'Brien at various times. Did you have any particular relationship of -- whether professional or friendship -- with Mrs. Brownlee? 10:24
A. It would have been a friendship, knowing -- from a CURE perspective, it was very much a social aspect. Mrs. Brownlee was Chair of the Trust and would have been on some of the interview panels for consultants. That would be right. And that was purely work. 10:25
29 Q. Did she ever engage with you in relation to Mr. O'Brien and the difficulties that he found himself in? 10:25
A. No, I don't recollect any conversations.
30 Q. Thank you. You were also for, I think, the majority of your time as a consultant also the clinical lead or the

lead clinician in respect of the Urology Department; isn't that right?

A. From about 2000/2001, yes.

31 Q. We will look at that role closely later in your evidence, but just to give us an initial heads-up in association with it, if we go back to paragraph 1.5 of your statement, WIT-51684, you describe it at that paragraph 1.5 as a role which was service-driven in terms of its organisational responsibilities, which focused upon the urology medical team's daily work placement. 10:26 10:27

So in terms of that role, and, as I said, we will look at it in greater detail later, what were the formal aspects of that role in terms of regular daily or weekly activity? 10:27

A. As I say, I saw the job as a service driven organisational need. It was to support our Head of Service, Martina Corrigan. So there was an organisational and a medical aspect and, if Mrs. Corrigan needed an angle from a medical perspective, she would come to me. Whether that was on a daily or a weekly basis, it was as necessary. 10:27

I think the main role or one of the primary roles was to do the rota for the whole unit, and that was to define the morning and afternoon sessions for all of the clinical activities in the unit for all the staff from a medical perspective; and then, having defined 10:28

that, the nursing angle would fill in their slots around that.

32 Q. Yes. And as appears from your statement, you have a particular perspective on the, I suppose, on the limits of that role in terms of responsibility. And that perception or that understanding may not necessarily be shared by others and I want to, I suppose, confront you with that or ask you about that later in your evidence. So thank you for that for now. 10:29

Just one final point on that. You never had a job description for the clinical lead role; is that correct?

A. Never.

33 Q. Another string to your bow, as we can just catch there at paragraph 1.5, was that you held a post as programme director, obviously external to the Trust, for urological trainees in Northern Ireland and, subsequently, you became an educational supervisor when the programme director role ended; is that correct? 10:29 10:30

A. I was an educational supervisor before and after. It's the Northern Ireland Medical and Dental Training Agency; it's the training programme for all of Northern Ireland. You know, it will have surgery and medicine and, from our perspective, we had a defined urology training programme. 10:30

34 Q. You explain, if we just scroll down to WIT-51695 and just scroll to 5.13, you explain that in addition to the list of duties in the programme director's post,

the programme director had responsibility for looking after doctors in difficulty. And you have referred us to WIT-51880, which is a document associated with, I suppose, how to manage doctors and dentists in difficulty published by the Agency to which you have just referred, the Northern Ireland Medical and Dental Training Agency, and I just want to pick up on a couple of strands contained within this. 10:32

It explains that this is a policy which has been written with a view to defining the procedures for dealing with doctors and dentists in the training grades who are experiencing difficulties within the Northern Ireland deanery, and the policy aims to promote early identification of trainees in difficulty and to provide a clear structure for identifying and addressing these difficulties. 10:32

And then if we scroll down to Section 3 of the policy or the guidance, it talks about identifying trainees in difficulty: 10:32

"All possible steps should be taken to identify and act on early signs and symptoms of difficulty. The majority of these are behavioural, but also include signs of clinical incompetence, for example, poor record-keeping, poor clinical decision-making and judgement, inappropriate referrals..." 10:33

-- etc. And then it goes on to refer to what is perhaps a priority, which is to try to successfully remediate trainees or doctors or dentists in difficulty, and it says that requires an understanding of the underlying problems. 10:33

I don't want to delve into the document beyond that, but do you see in that guidance some relevant themes or potentially relevant themes in terms of managing doctors who are fully qualified, not necessarily 10:34 trainees?

A. It moves from one to the other, yes.

35 Q. Yes, and highlights, by way of example, some of the things that those responsible for managing trainees in difficulty might have in mind. And, I suppose, one of 10:34 the themes is to get to the issue early, to identify things early and get to work on it.

Were you -- and I might add there's probably loud echoes of this document or the themes of this document 10:35 in the MHPS process or framework -- were you familiar with that, the Managing or Maintaining High Professional Standards framework?

A. No.

36 Q. Let me bring it up on the screen, WIT-18490. I keep 10:35 using the word "Managing", but it's "Maintaining" --

A. Maintaining, yes,.

37 Q. I haven't cleared that in my head after 12 months -- 24 months! So -- and this is maybe just an initial

fact-finding exercise with you -- this document, as you can see, published in 2005 by the Department and was to be used inter alia by employers for the purposes, essentially, of managing doctors who are qualified and get into difficulty. Is that something that ever crossed your desk by way of information, by training, even if you weren't implementing it? 10:36

A. Yes. I'm sure this has come across my desk, but to go through it on a formal basis was what I meant by my last answer. I haven't had any formal training in the content of this document. 10:36

38 Q. The Trust produced its own guidelines as a companion piece to MHPS -- if I could just bring those up on the screen, TRU-83685 -- published in 2010. Again, self-explanatory headline -- 10:37

A. Yes.

39 Q. We'll maybe go into some of the nuts and bolts of it a little later, but any familiarity with those guidelines?

A. Yes, I recognise this as a document. I understand it was quite a long document. 10:37

40 Q. These things are all relative!

A. Yes!

41 Q. But in terms of, yes, you recognise it, we'll come, as I said, later to your role as clinical lead and what might have been expected of you, particularly in association with Mr. O'Brien, a doctor who arguably was in difficulty. 10:37

Had you any training or working experience of this document?

A. I don't remember being taken through this by the hospital management. These things are often sent to you with the expectation that you read them. 10:38

42 Q. Yes. Thank you for that. Now, the environment in which you worked for 20-odd years has been, I suppose, the subject of detailed commentary by yourself in your witness statement. I think it's -- I suppose, it's fair and appropriate to explore that a little with you 10:39 so that you can provide the Inquiry with, I suppose, the benefit of that context. It was a context which was often challenging for all of the consultants employed within Urology and it does seem at your -- reading between the lines in your statement -- that the 10:39 foundations for the Urology Service were never quite correct, never strong enough, and that led, perhaps, to difficulties in dealing with the demands of the local populace throughout your career. Is that a fair summary of what you were exposed to? 10:40

A. That's a very fair summary. Going back to 2001, there was a Trust recovery plan and, from a urology perspective, we were noticing a 60% increase in our emergency workload. Our referral rates were going up exponentially, and that was in 2001. 10:40

We then, over the next few years, linked with Mr. Templeton, who was the Chief Executive at the time and had his office on the top floor of the Hospital.

He was easy to talk to, and we would have put our case across. And it actually got to such an extent that our emergency workload was overtaking the system completely and we asked to close the doors for a period of time.

10:41

We also had outreach clinics that we were meant to go to which then didn't leave anybody on site in the main hospital and we felt that that was an issue from a safety perspective. And it all came to a head, basically, and Mr. Templeton did listen to what we were 10:42
saying and he called for an external review of the Urology Services.

43 Q. I'm going to pause there because I want to do a little bit of backfilling before we reach the McClinton review, which you talk about at some length, helpfully, 10:42
in your statement.

A. Right.

44 Q. There were, in essence, three reviews that are maybe worth mentioning this morning -- the McClinton; then into a regional review in 2009; and then roundabout 10:42
2014, something of a stock take on the regional review.

A. Mm-hmm.

45 Q. But let me set out, I suppose, the broad thing that's to be divined from your witness statement. It's set out at 1.8. So if we go to WIT-51684, and just down 10:43
the page at 1.8, so I suppose this is really a state of the nation kind of description of what you and your colleagues worked in:

"A theme which has coursed throughout my tenure has been the demand put on the Service from the significant numbers of patients requiring investigation and therapy within a deficit in the healthcare system capacity in terms of both facilities and provision of healthcare staffing. This has resulted in particularly long urology waiting lists for both outpatient and inpatient assessments. The yet undiagnosed and potential hidden pathology is a distinct concern. For those with a known condition, they suffer from a lack of intervention." 10:43 10:44

And you go on to say later in your statement -- this is paragraph 54.1 -- that during your initial, you said, ten years or so in Craigavon, it was evident that there was a struggle for the Trust to appreciate the level of need the Urology Department required. And then we have the McClinton review in 2004. 10:44

Just before we unpack why that review was asked for and what it produced, we should remind ourselves -- when you took up your consultant's role in 1998, Mr. O'Brien was there; he was the sole or single-handed urological consultant, is that right? 10:44

A. When I took up post, yes. But there had been a consultant, Mr. Baluch, there. I think I came to replace him, as opposed to being the third person. 10:45

46 Q. Yes. It was part of the drive that was to come over the next few years, was to try to persuade the powers

that be that a third consultant was necessary, isn't that right?

A. And potentially more than three, yes.

47 Q. Of course. Just in terms of the impact on the two of you coping with what you briefly described as the big increase in emergency work, in referrals, and that kind of thing, what was it like in terms of pressure? 10:46

A. You lived in the hospital. It was a one-in-two on-call rota as a consultant. There were registrars, but they did not cover the whole week, so you may be on call yourself. So that's a one-in-two weekends. Work for week at a time. You did your daytime work -- clinics, theatre -- and then you were on call, and all of the admin and triage to go with that. When your colleague went on holiday, you were on call for two weeks solid. 10:46

48 Q. Belatedly, was, I suppose, the weight of those responsibilities recognised with a contract of 15.4 PAs -- or 15.6, I think, is the correct --

A. Yes.

49 Q. -- as an ex gratia payment? 10:47

A. That's correct. We did have job plans, but it was all the extras, it was the administration and the on-call and the recognition of that, the one-in-two rota, we felt was important to sort of cover. We didn't get any summer cover. There was no -- in those days, there weren't any sort of locum consultants coming in to sort of cover the place. 10:47

50 Q. When you think back now, what I'm trying to explore with you is whether the foundations of this service,

this urological service -- which is obviously in a quite different place today than it was in the mid 90s when you came along and, just before that, Mr. O'Brien came along to establish the service -- but help us with this: Was urology regarded as some kind of Cinderella interest or area by those in power within the Trust, or was this sort of struggle to get it going and get it resourced perhaps a factor of the context in which it started? There had never been a Urology Service until Mr. O'Brien came along -- or not formally one. How do you explain what you go on to describe, or we'll explore with you, the constant struggles? 10:48 10:49

A. Okay. I have to go back further. Mr. Graham was a general surgeon in Craigavon and he had, obviously, a main surgical interest, but he also had a urology interest. He would have done TUR prostates. I was his registrar at one stage and, from a urology perspective, it was to do sort of TURPs. There wasn't anything else. The TUR -- also bladder tumours -- would have gone to Belfast. So I think urology might have been thought of as a one-operation service. But as will be known from the top desk is that it's not just all about TUR prostates. And urology then evolved and there was a formal training programme in urology in the 80s, as you know, and Mr. Graham was replaced by a general surgeon and a urologist, Mr. O'Brien. 10:49 10:50 10:50

So, Mr. O'Brien would have introduced much more to the overall wing of urology, moving on from the prostates

to the likes of bladder tumours and etc.

So it was then trying to -- and, again, in the 90s, the only urology centre was at the Belfast City Hospital, so probably one of the prime reasons why a unit in Altnagelvin and in Craigavon opened up was that it was observed that the Belfast service wasn't catering for the whole of NI well enough, and that's why the other places have opened up. 10:51

But when you have trained urologists going in, you're going to introduce an awful lot more procedures and care, and a lot of work came out of the woodwork, shall we say. So when the GPs realised that a certain condition could be treated more on a local basis, then I feel that that's when there was an escalation in the number of referrals in principle, and not just having to be sent to Belfast. 10:52

51 Q. That development, that expansion of need, are you saying -- and certainly you appear to be saying in your correspondence that there was a slowness on the part of the management, senior management, within the Trust to recognise and resource -- recognise, first of all, and then eventually it was recognised, but then to resource all that came with it? 10:52 10:53

A. Yes. I don't think that they fully appreciated the range of services that we could have offered. And when the GPs learned about it, there was an increase in volume and I don't think the Trust really had -- had

left us to get on with it, basically, but maybe not appreciating the volume.

52 Q. Yes. And some of this is reflected in -- sorry, I cut across you?

A. No, no, you haven't. 10:53

53 Q. Obliged. Some of this is, of course, reflected in the correspondence between you and the Chief Executive, you and the Medical Director in the early noughties. Let's just pull up a few examples of that to illustrate the point. WIT-052068... No, that may not be... That's it, 10:54 thank you (52068).

So you're writing 19th August 2002 to Dr. Liam McCaughey, who was Medical Director at that time. Just in the first paragraph, I suppose, it sets the tone. 10:55 You're saying that you have, in previous correspondence and meeting:-

"...expressed grave concerns about the Trust's provision of services to our urology population and 10:55 urology manpower. These two points are closely interrelated, but they are two separate issues."

And you go on to expand upon that. Waiting times are a big problem. And then in terms of impact on 10:55 manpower, you talk about the expectation in terms of the work to be performed is currently far too excessive.

Just let me go, maybe, to the last paragraph of the letter. The Panel can read this in full, so I'm just picking up on broad brushstrokes, I suppose:

"The Trust has been aware of our concerns for over one year." 10:56

And you're saying:

"I doubt if the Trust has informed the Board of the same. This may be appropriate in view of the eminent plans." 10:56

"Imminent" plans, maybe.

"Since there has been little progress, I am referring this issue back to the LMC..." 10:56

-- that's the local...?

A. This is the consultant sort of job pay, basically. 10:56

54 Q. Okay. So, I suppose this letter contains a flavour of the concerns -- a degree of frustration that the Trust isn't listening or isn't moving fast enough on those two interrelated issues? 10:57

A. Correct.

55 Q. Just by way of another example, you write then to the Chief Executive a year or so later, 17th September 2023, and we'll find that letter at

WIT-52092. And if we just scroll down to the next page, please, and just in the middle of the page, this probably catches in a nutshell what you're saying:

"Since taking on the lead clinical role several years ago, we all acknowledge that there were difficulties and shortfalls in the ability to cope with the volume of urological workload." 10:58

You say: 10:58

"I feel I have put a considerable amount of time and effort into trying to address the urological issues with a fair and logical approach."

10:58

First, you define the problems using data supplied by the Trust, and, secondly, formats to supply urological provision and national guidelines were presented as a model to the hospital.

10:58

"Both these presentations were fully accepted by yourself and the Medical Director earlier this year. At this stage, you stated that you would give a written indemnity to cover the urological service status. This would appear to give full support, despite the known difficulties. 10:59

On this premise, we have been working towards defining an adequate and acceptable way forward."

But you say the goalposts have shifted and what you thought, I think, was progress towards a third consultant had not developed in the way that you thought it should. And, at that point, it was decided that there would be an external review.

So is it fair to say that progress was very slow?

A. Progress was made, but slowly.

56 Q. So the next stage, I suppose, was the McClinton review. Mr. McClinton was a Scottish urologist? 11:00

A. Mr. McClinton was a senior urologist in Aberdeen, and I knew Mr. McClinton well. He was an endourologist. He was born in Northern Ireland, so he knew the set-up, although I think he did all his training across the water. So he -- and the other aspect to that was I thought that the Scottish system would have been fairly similar to the urology set-up here in Northern Ireland, rather than what was based in London, for instance.

57 Q. You, at WIT-51722, provide us with a summary. Just scroll down, please, to 15.9. You provide us with a summary of the findings of the review or its recommendations. Let's just scroll down through them. For example, at (c) it's proposed that there would be increased use of available urology nurses. At (d), the appointment of a third consultant urologist and appropriate support staff. That's something, I suppose, you'd been campaigning for for some number of years?

A. Indeed.

58 Q. At (e), there is talk of a need to redesign and modernise urology services, and, at (f), investment in creating additional capacity, including inpatient bed and day case capacity. 11:02

At (i), just moving down, the appointment of a fourth consultant urologist and support staff appointment; and, at (j), dedicated urology specialty nurses. 11:02

You go on in your statement and we can see in the correspondence that you largely welcomed the recommendations, but then, as we can see, for example, at paragraph 15.21 of your statement, you talk about inertia on the part of the Board and the Trust in terms of the implementation of the review recommendations. What happened? There was a locum consultant appointed, is that right, and then Mr. Akhtar was appointed, but you never got to a fourth consultant; is that fair? 11:02

A. I think the inertia referred to the McClinton report came out in 2004, and we thought it would have been faster, all of those (a) to (j), being at least started on the process. But it took the Trust a while to get the wheels in motion, as such. 11:03

In saying that, the wheels in motion was, maybe, slightly larger than I was aware of at the time in that they had the Aspen. This was to clear the backlog to a certain degree and we had -- it's an Australian 11:03

surgical unit that was very mobile and they came to South Tyrone and set up camp, basically, for a good number of months and they tackled our outpatient -- sorry, tackled our inpatient surgical lists.

11:04

So that was going on in the background. And I thought on the second vein that, for our service, that these recommendations would have been started a little bit faster, i.e. in 2004, rather than leaving it to the end of 2005. Sorry, I was being impatient. I was hoping 11:05 that they would move faster.

59 Q. In concrete terms, what did the service get as a result of the review?

A. Yes, okay, so engagement was part of our departmental meetings on a Thursday. We set out to work through all 11:05 of the list. It was about redesigning and remodelling what we were putting across. And we set up individual outpatient clinics -- like, a prostate clinic, haematuria clinic, andrology, female. So it was a themed outpatient process. We were engaging with our 11:06 nurse specialists. These were senior nurses from the ward. It would be a start to the CNS process, basically.

So we were designing a nurse-led and also a GP with 11:06 specialist interest form of clinics. I was keen that we had this under the one roof principle so that the doctors and nurses were together. They could ask questions -- if the nurses felt they needed a bit of

advice, there was a doctor on hand, and that was important. That's where we got our -- we were originally promised the Ramone building, which was part of the main hospital, which would have catered for all our needs, even until today, but there was a closure of the Skins Department in Lurgan Hospital and they got our space! But the Trust built us a big porta cabin, if you want to put it that way, on the hospital site, just specifically for us, and we named that Thorndale. And it was a specific building just for us. And within that, that's where we put our service. 11:07 11:07

This was a year ahead of the ICATS service that the Department of Health were keen to move to. So ICATS is integrated care. It was that bit between sort of GP and the hospital site, to try to reduce the number of hospital referrals. But certainly our sort of building of this was just right up the alleyway off the ICATS service and it led to it very, very well. 11:08

60 Q. Yes. Your answer suggests that although the service -- although the demand for the service had grown too quickly or quicker than the service could actually respond to, the outworking of the McClinton review, albeit rather tortuous and slower than you and perhaps Mr. O'Brien would have liked, at least for the first time, perhaps, put in place something that -- something of a framework or foundations from which the Urology Service could begin to thrive. Is that what you thought at the time? 11:08 11:09

A. Yes, and our ICAT service was very good. It did have an output. We had worked out our clinics and volume as appropriate to the number of referrals coming in. And at the same time the surgeon who had worked for Aspen stayed on as -- we then advertised -- we took a third position as a locum consultant, and that's where Mr. Batstone came from. He had worked for the Aspen team, he was English, and wanted to come home -- it suited well! So he came as the third consultant, as a locum to start with, and then we advertised the post and Mr. Akhtar got that post. 11:10 11:10

61 Q. Yes, so that was three posts, not four, just to be clear?

A. Absolutely. It was three posts. I know that Mr. McClinton here had recommended a fourth post by 2007, but we only got the three posts. 11:10

62 Q. Yes. Let me move to the regional review. The regional review came in 2009 and, ultimately, I suppose, the headline is it proposed a three-team model, and Team South was to be centred in Craigavon with responsibility for a population of 410,000, spreading out to Newry and further afield into Fermanagh. Let's look at that briefly. 11:11

You set out at WIT-51699, at paragraph 9.3, some of the key recommendations. You, just scrolling through those -- I suppose, the headline, again, was the expansion of the service at Craigavon in terms of the number of clinicians who would be employed there. How did that 11:11

process work out and what was your role in it?

A. My role in?

63 Q. Your role -- after the review, you took a position in the project steering group for the purposes of implementing the review; isn't that right? 11:12

A. Yeah, that's correct. Right, okay. Yes, after the review, they had set out, I think, 21 things to get through and the Trust worked through these implementations. And, as you say, one of these related to the number of new consultants. Our issue there was 11:13 a resource issue -- where were they going to be working, number of theatre spaces, day surgery, and clinics. We had to do a fair amount of work to try to make that fit. It got to the stage where we were looking at a three-session day -- morning, afternoon 11:13 and evening theatre lists. We only had the one theatre, Theatre 4, sort of allocated to urology, and I was trying to squeeze as much out of that as we possibly could.

64 Q. Just on that, and one of the themes that we'll move on 11:14 to look at in a moment is the ability of this service to deal with the demand. Given, I suppose, the infrastructural constraints at Craigavon and, indeed, even taking into account some of the sort of satellite hospitals, given the difficulties of recruitment and 11:14 that kind of thing, was this proposal, which was implemented for a Team South, excessively ambitious with the benefit of hindsight?

A. No, I don't think it was ambitious. It was a good

master plan. It took time for us to work through it all and the employment of the extra surgeons took time. There is no doubt about that. There is an original sign-off in 2011, I believe, but, yet, the time it took to get to advertising posts, to have them interviewed, and then for who we employed to take up post, you know, took right through 'til 2013, I believe.

65 Q. Yes, interviews appointed three consultants in late 2012 and it was into 2013 --

A. -- 2013 that they actually came to work. So there was a void there of several years. And in the middle of that, I think Mr. Akhtar moved at one stage, so we were actually back down to two.

66 Q. Yes. You say in your statement that -- this is paragraph 10.9, if we can go back to that -- but, to summarise, you're saying that the process didn't achieve its aims and, here, you're pointing to -- I'm just bringing you to the page -- the process didn't achieve its aims, at least, it seems to be, in the short-term in that the roll-out was slow, understaffing in the unit in medical terms, and as well on the nursing side?

A. Yes.

67 Q. Is that meaning to suggest that in the short-term it didn't achieve its aims, or are you broadening it beyond that?

A. No, it's very much in the short-term. So we had spent time working through our theatre list allocation. We were looking at our day surgery facilities -- our

outpatient facility, as I mentioned, was Thorndale -- the principle being all being under the one roof. There was a fair amount of discussion with the higher authorities in that we had a pathway that we wanted to go down in how we delivered the Urology Outpatient Service. As I say, we had the experience of the ICAT service before hand -- nurse-led, doctor-led, and investigations. I did spend a lot of time with the team then and drew up a second outpatient facility, now named Thorndale Mark II, but it was really trying to define the amount of work that needed to be done, the number of rooms required to make that happen. I had several sort of master plans, from a very straightforward outpatient design to one that was, well, had all singing and dancing activity in it with outpatients' rooms, consultants' and secretaries' rooms all in the one area so, you know, you're all under the one roof principle. And we sort of settled for something in the middle, which is our Thorndale Mark II. And when I learned that they were accepting what I was trying to put across, I sort of knew that we were heading in the right direction. It's right next to this orthopaedic suite, so I think it all got built at the same time.

11:17 11:18 11:18 11:19 11:19

So we had worked out how many rooms we needed, and we got how many rooms we needed, and that was built around this time and it's still our facility at the moment that we work from. So there's five consulting

rooms and then two investigative rooms. One was for flexible cystoscopies and urodynamics, and the other one was an ultrasound room. And our clinic design at the beginning was that you could come to a clinic and have an ultrasound or your TRUS prostate biopsy on the same sitting, but it was all under the one room -- the one floor space.

68 Q. Yes?

A. So that took time to put across, it took time to build, but it's what runs currently. 11:20

69 Q. Yes, but at 10.6 you make the point, if we just scroll back, that in terms of the plan to centralise services at Team South for this population, that there was an overestimation of the actual workload that was possible. Has that been, I suppose, a design fault that has permeated the service since the attempt to implement this back in 2014, and in part explains why the service has been forever chasing its tail in being able to meet demand? 11:21

A. Yes. These were my -- these were my sort of calculations of what was needed. At this time, the Department of Health had a S.A.B.A; it was a contract of a volume of work that you were meant to get through. And I sort of knew that the way our clinics were, that we would never be able to attain that level. And I felt that we were still short of what we were able to provide. And, on top of this, there was still a backlog. So we were never starting with a clean slate. We were always, as you say, we were always 11:21 11:22

chasing our tail. But we were chasing our tail on two fronts -- one, that there was already a backlog there and I felt that, maybe, we were -- that the expectation of what we were trying to put across was still going to fall short of the mark. 11:23

70 Q. There was a stock taking in or about 2014 that looked at how the service had fared since the implementation of the internal review recommendations. And, as you point out, some of the recommendations were only just freshly implemented so, by the time of the stock take, 11:23 the additional consultants had just come into place. Some of them, Dr. Connolly and I think Mr. Pahuja, didn't stay very long and they were replaced, ultimately, with Mr. Haynes coming in and Mr. O'Donoghue coming in? 11:24

A. So here we have a service that was starting -- new blood come in, new blood leaves very quickly. So, again, we were on the back foot fairly consistently and still stuck with three consultants. It was only then when, as I say, when Mr. O'Donoghue and Mr. Haynes 11:24 arrived that the service has been stable at that number. So we were short of consultants.

71 Q. Yes. And it was your sense, I think, as reflected in your statement, that really the Trust was much too slow, for whatever reasons, to make the necessary 11:25 recruitments?

A. There's potentially two angles to that. One, there's a slowness in the Trust to re-advertise a post. They always wait until somebody leaves before they

advertise, instead of when somebody hands in their notice that you would expect maybe an advertisement goes out at that stage. So there's always a delay between somebody leaving -- or there's a delay between somebody saying they're leaving and somebody arriving, and that's been extended.

Our issues have also been in recruiting people. We have had advertisements go out and have either had no applicants or applicants that were not at a level that we would have wanted.

72 Q. I think you make the point, this is at paragraph 16.3 of your statement, at WIT-51728, that from -- it was only at August 2014 that -- this is paragraph 16.3 -- it was only from August 2014 that you had a complement of six consultant urologists. But then Mr. Suresh left in October 2016, so that there's only been a brief period throughout the last ten years or so when the service has had its full complement of, I suppose, tenured as opposed to locum consultants in place? 11:25 11:26 11:26 11:27

A. I think you could count that length of time in months!

73 Q. And, more seriously, what have been the consequences of that or the implications of that in that period of time for the service?

A. Well, if you don't have a consultant there, you're not going to have output. That consultant's work is then moved to the other consultants to take on board, potentially. So there is ever-increasing demand. I mean, each year goes by that there's increasing 11:27

referrals done to the system, but, yet, the people that are offering the output are predominantly surgeons and, if somebody leaves, somebody else either has to -- has to pick up that slack. That slack has been picked up from an emergency perspective, but not on the elective side. So our emergency inpatient work would have been covered, but the increasing demand was not getting -- I think it's fair to say that all the consultants work very hard. All of their clinics are full. Our theatres are full to as maximum as we can. Maybe, coming back to my sort of monthly rota plan is that, during that -- we have a meeting once a month to actually cover the rota for the month that I mentioned earlier and, at that meeting, although there's a basic plan for the months laid out, we then would have to find the spare slots. In other words, if somebody was on leave, somebody was on call, their theatre list would be free, in theory, and we then, as a team, instead of letting those theatre lists go, we would shift our own workload around to take up that slack. It may have meant that we dropped something else or we moved our SPA to a different time, but the team were there and maxed as much of the theatre space as possible. But, yet, it's hard to sort of keep up with the extra work coming through. 11:28 11:29 11:29 11:30 11:30

74 Q. Could I, just before we break, look at two other points around staffing? It wasn't just the consultant grade, it was the staff grade as well where there were difficulties. You, I think, helpfully created

a table -- I think it was your work -- at WIT-52261 -- which sets out, I think, pretty -- was that your work? Maybe not. It sets out, in any event, fairly consistent or persistent vacancies from 2009 through 2022, although some improvement, it seems from around about 2018. Can you briefly speak to what this is telling us in terms of vacancies and the implications of a shortfall in the staff grade?

A. Okay, so our Outpatient service, our ICAT service we were talking about that works in Thorndale were run by our clinical nurse specialists and staff grades. Dr. Rogers there, you see on the top line, he was a GP with a specialist interest in urology. We then had a series of staff grades, as you see, from 10, 11 and 12 there. They were primarily to help in the outpatient arena and they would have had clinics on their own, obviously under our wing and supervised, but, you know, they were having an output. They would have helped out with the flexible cystoscopy lists etc.

11:31 11:32 11:32 11:33 11:33

So those clinics are all set up and would be sort of running for a year, and if they were coming and going, there was nobody to fill the void. It was at a level at that stage that our nurse specialists wouldn't have been at that precise level to have covered the area. So this was a distinct void of sort of clinic output.

75 Q. There was also a gap in the nurse specialist number for a considerable period of time, it seems. I think the target was, arising out of the various reviews, was to

reach five, but that number wasn't achieved until in or around 2019/2020?

A. Yes, I think this was an employment thing. I don't think it was a turnover of staff, it was the advertisements and employment and the ability to recruit into the post became a challenge. So, all in all, our sort of middle grades and our nursing volume, there was a significant void there for a five-year period, say. 11:34

76 Q. Another feature impacting or causing a difficulty in the service's ability to impact on demand was theatre availability? 11:34

A. Theatre availability is on two fronts. One, there are only so many theatres in Craigavon, of which we are assigned to one. And if, say, there's six consultants trying to share all that, that's -- we're all scrambling for the same space is number one. 11:35

The second impact is the winter pressures and the staffing. The nursing staffing facility had a high turnover as well, more from people retiring. So our winter pressures, for instance, just to give an example is not just closing down at Christmas time because the hospital is full. I mean, our winter pressures were getting as far as April at one stage, where there was a 30% cut in the theatre list allocation. Now, that's a substantial amount of lists that are being cancelled. 11:35 11:36

MR. WOLFE KC: Yes. I think, with the Chair's leave, we'll maybe take a break now? We'll return then and

look in a little more depth at the consequences of the implications of the context that you've just painted and what staff sought to do about it and its impact on staff. So we'll take that up after the break.

CHAIR: Okay, we'll come back, ladies and gentlemen, at five to twelve. 11:37

THE INQUIRY ADJOURNED BRIEFLY AND THEN RESUMED, AS FOLLOWS

11:37

CHAIR: Thank you, everyone.

77 Q. MR. WOLFE KC: So, Mr. Young, you've painted a picture very clearly of, I suppose, the resource deficit, particularly in terms of staff, across consultant staff grade, as well as nursing, married with resource difficulties to some extent, in any event, in terms of theatre provision. 11:55

You say in your statement on a number of occasions that, in essence -- if we could, perhaps, pull up paragraph 16.6 at WIT-51729 by way of example of -- so you're saying that this shortfall in the expected numbers of consultants results in a deficit of provision in overall output of FCE. Does that stand for "Finished Consultant Episode"? 11:56

A. Correct.

78 Q. And is the period of continuous care provided to an admitted patient with one consultant as the healthcare provider? 11:56

A. Yes.

79 Q. So that's one of the deficits. It has led, as you explained here, to outpatient elective surgery episodes and hindered target achievement potential. You go on to describe reduced productivity, disjointed patient care, new personalities having to be engaged and integrated and learn the systems. 11:57

Elsewhere in your statement -- for example, paragraph 17.4, if we could just scroll down -- that the shortfall in consultant number, this is WIT-51732, the shortfall in consultant numbers have had a significant impact in terms of backlog and that has never been adequately addressed, either by the Trust or the Department. And the consequence of this is both in terms of volume, that is the overall number of patients needing to be seen, and the timeliness with which you can reach those patients. And then this log-jam effect you describe as having an impact in terms of hidden -- you say hidden oncology, but, more generally, there's a hidden pathology across all categories of patient? 11:57 11:58 11:58

A. Yes.

80 Q. Indeed, I think, as we'll see in a moment, the priority, perhaps necessarily, had to be given to oncology patients, and it was the other patients who couldn't be treated as urgently or policy dictated wouldn't be treated as urgently where the real concern, perhaps, existed? 11:59

A. Our system is a red flag, urgent, routine. Obviously,

the red flag refers to the oncology workload. It would come to the top of the list of being treated, at the expense of what's classified as routine. Routine would be the benign side of the fence. And, in urology, the actual risk of infection is high and men with catheters in, stones, still classified as routine or urgent, are left to a certain degree at the expense of the oncology work.

81 Q. Obviously, I hope, it is the responsibility of the Department, the Commissioner and the Trust collaborating to provide the resources so that you could, as clinicians, deliver as against the demand that you were facing. Did you get a sense as clinical lead or simply wearing your consultant's hat as to what was being done to meet the demand that was clearly reflected in the waiting lists across all of the indices? And we previously opened those waiting lists and I don't think we need to do it again today. What was your sense of what was going on to assist you clinicians to deliver an adequate service? 12:00 12:00 12:01 12:01

A. Well, if we -- there's going to be inpatient, but there's going to be -- there's going to be theatre cases and there's going to be outpatient work, okay. There was always going to be difficulty finding extra theatres. To buy a theatre costs millions of pounds. That wasn't going to be an option, particularly. The Trust did do waiting list initiatives where we would have maybe not so much had lists in the evening time, but there were lists on Saturdays. They employed the 12:02

independent sector to take on extra work as waiting lists, but again this was ad hoc, dependent on a financial budget to pay for it. It didn't run on a regular basis and, as I say, it was on an ad hoc account. Same for outpatients. 12:02

I think most of the work in previous times was looking at the theatre lists, as opposed to the outpatient list. In more recent times, the independent sector has been brought in to look after the outpatient arena, 12:03 but, again, that's, from my knowledge, only of a recent event and is more consistent, whereas before it had been all very much ad hoc -- going back to this 2015 area.

82 Q. Yes. Given this context where, as a group of senior 12:03 clinicians, you are recognising that there are a large number of patients in your constituency in the local populace who are realistically not going to be seen for a long period of time if nothing changes and that creates morbidity, inevitably hidden, perhaps, because 12:04 until they present as an emergency in extremis -- was this creating real-world dilemmas for you as a team of urologists or, indeed, in your individual practice?

A. It will have been in all our practices. We all have a general urology interest, so we will be looking after 12:04 all the patients on our waiting lists. This level of waiting list length, both in volume and in time, is certainly -- was, certainly, known to the Trust and the Department of Health. They had been told. I mean, the

figures are on paper that they collect themselves. So it doesn't take us to tell them the volume. The actual nature of the outcome of that is that patients that were of a routine nature were then coming in on an emergency list, as such, and were being looked after that way, and, with that, an emergency admission takes much longer to look after in terms of time than an elective case that might have been done as a day case. So there was a bed occupancy effect with that elective lot of patients now becoming emergencies and taking longer to address. So it all had a knock-on effect. 12:05 12:06

83 Q. In terms of your own practice, were you often thinking or sometimes thinking, "Well, I could mitigate the risk by doing X, but that's going to have an impact on my ability to do Y in terms of my responsibilities that generally fall within my practice and, therefore, I'll prioritise X but it's going to lead to slippage in aspects of my other work" -- was that a dilemma that ever confronted you? 12:06

A. That confronts you all the time, yes. Choosing your cases for a theatre list, if you're from -- for instance, from my perspective, from stones, I'm going to try to choose patients that I identify are at higher risk than another group. But knowing that the other group is also still at risk, you have to do a bit of juggling. So I may do three or four ureteroscopies as opposed to doing one sort of PCNL, which is -- which takes -- I mean, sorry, a PCNL is a stone that involves the whole of the kidney. And, also, we know that that 12:07 12:07

group of patients are at increased risk of loss of kidney if it's left for an excessive period of time. But I would have had to sort of balance that up against a stone that's in a ureter that's causing obstruction that is higher risk of causing a septic episode, coming in as an emergency, potentially needing to go to ICU. 12:08

So, yes, we would have had to choose. A man who has a catheter in -- again, increased risk of sepsis -- you're more likely to give him a date above somebody that still needs the same operation but is not having a catheter in. So, yes, there is an element of having to pick and choose, and definitely an onus on us to be sort of making that choice. Is that the question you're asking? 12:09

84 Q. Yes. And is there another element to it as well, or perhaps not, in, for example, volunteering to participate in a waiting list initiatives or doing more theatre sessions --

A. Oh, right, okay. 12:09

85 Q. Would that potentially impact, for example, on your ability to progress the administrative side of your practice and lead you to not doing it or delaying in doing it?

A. By -- sorry, I don't... 12:10

86 Q. So, there's only so many hours in a day. You have your standard work plan --

A. Right, okay. Yes, sorry, I understand now.

87 Q. Sorry.

A. Okay. Yes, coming back to that business of running the rota, we try to max out as much as we could of theatre space, so you would take that up. That time that you are taking it up, you are then offloading to a different time. So, yes, it adds, undoubtedly, to the work that you do Monday to Sunday. So, yes.

88 Q. Take, for example, Mr. O'Brien. I understand that between 2012 and 2016, he performed 112 additional elective operating sessions over and above what would, I suppose, be expected of him. Would that -- would you recognise that there's almost an inevitability in prioritising those patients in order to, perhaps, mitigate the risk of them becoming more unwell, and perhaps they're unwell already, that that will inevitably impact on the performance of other duties?

A. When you take on these extra time slots, it's clearly done that you can cope with doing the extra. For instance, you were talking about a waiting list initiative on a Saturday -- this is all about your choice of whether you want to or can do. But this is in addition to what you do; it is not to displace what you were already assigned to do.

Maybe just following on that exact point and coming back to the rota that we were talking about -- sorry, I know I'm talking about the rota a fair wee bit, but it's quite important, this meeting. For instance, if we knew that somebody was on leave or on-call and their theatre lists were free, when going through all of

this, if I had observed that somebody was trying to take on too much, then I would have politely said, "I think you're doing too much" -- and specifically you comment Mr. O'Brien here -- he would say that, "Look, I would like to do this extra -- extra, extra" and on several occasions I've said, "Look, Aidan, I think you're trying to cover too much this week" and I would give it to somebody else. So, you know --

89 Q. That was your role as clinical lead trying to get a sense of all of these moving parts and -- 12:13

A. It's very much trying to get all the cogs lined up. But, you know, if I saw somebody was -- and the Trust gave out these extra lists or extra sessions, but they were asking, they weren't telling. So, you know, they would say, "Look, here's an extra list, can anybody take it?". It wasn't sort of saying, "Right, here we are, we're going to divvy all these out between..." -- that's not the approach that they got. So they -- the Trust said "Here's extra -- do you want to do it?", it's up to you whether you wanted to do it or not. And then, even within that, if it was at the departmental meeting, if I had seen somebody was trying to do too much, I would say "I don't think that's a good idea."

90 Q. So, to summarise it, you appear to be saying that it`s implicit and sometimes made explicit in the transaction or the conversation around the extra work that you are accepting it on the basis that you will be able to manage the other aspects of your practice that still need to be done and to manage it in a timely fashion?

A. Yes.

91 Q. Briefly, it appears that -- we looked at a couple of examples just now -- that the staff of consultant and nursing, and no doubt others, were not afraid of making noise and drawing attention to the imperfections of the system and its impact on the safe delivery of care and its impact on patients; is that something you found yourself giving voice to or did you leave that to others? 12:15

A. I think we all contributed to the same conversation. 12:16

92 Q. Mr. Haynes, for example, if we briefly look at a piece of correspondence from him, AOB-01811 -- here, he is writing to the Director of Acute Services, Mrs. Gishkori, in May 2018. In essence, it's an expression of concern that serious patient safety issues are flaring in the Urology Department, particularly in terms of the resource available for inpatient theatre waiting lists. And he makes the point in the third paragraph there that it is the clinically urgent cases that are at a significant risk as a result of ongoing -- primarily ongoing reduction in elective capacity. 12:17 12:17

He was to write subsequently to yourselves as a group of urologists suggesting -- this is in October 2019 -- suggesting the completion and submission of IR1 forms for any patient who has waited for an excessive period of time. 12:17

Did you have any sense that the Trust were approaching these issues -- and maybe it was a responsibility that goes beyond the Trust, but primarily the Trust because they were the deliverer of the service, but was there any sense that the Trust had a plan or a framework that focused on the issues that you and your colleagues were bringing to them, or was it, just to complete the sentence, was it very much piecemeal or a band-aid approach in the sense of waiting list initiatives every so often, that kind of thing? 12:18

A. It's that kind of thing. It's the Trust were aware of this, they were aware of the downturn in the sort of theatre capacity. I mean, there's the 30% I mentioned earlier. I think they didn't know how to cope with that because the Trust was already running at maximum efficiency, as far as they could see. They/we were thinking of alternative ways to try to address the issue. It's not that they were trying to sweep it under the carpet, if you want to put it that way. 12:19

I think the Trust were aware of the level of concern, both from us saying it and them seeing the actual numbers. But it was how do you address the problem? And, again, that maybe comes full circle to the sort of waiting list initiatives and thought processes of how this can be done or tackled, shall we say. And I think 12:19 12:20 the options of outsourcing the problem was the line to be taking, rather than the investment in the service. But investment in the service comes from higher up than the Trust itself. That is, undoubtedly, a Department

of Health problem. If we need extra theatre space, the Trust isn't going to build the extra theatre space. It's going to be at a much higher level than the Trust to be able to supply that.

12:21

I think our figures -- I mean, everybody will talk about theatre utilisation percentages and I feel ours are pretty good. I mean, it's never going to be 100%, but we've undoubtedly tried to use every spare minute that we have to provide, but, yet, still, the "in" is vastly better than the "outs", I'm afraid. So there's just not enough floor space or theatre time to do that. Is that what you're asking?

12:21

93 Q. Yes. And I suppose it crystallises in your statement where you say that this shortfall has never been adequately addressed by the Trust or the Department --

12:22

A. Can I maybe just answer that a little bit? Again, there has been the backlog and what you have existing. So, if you, again, have a clean slate and run an efficient service, you know, it's going to appear much better. But, again, with an inherited backlog of patients that then become sick and take longer to do, it's not just adding to the equation, it is multiplying the time required to look after it.

12:22

94 Q. I'm interested in your thoughts in relation to those patients languishing on waiting lists. Your statement speaks to the hidden morbidity. These patients eventually, in some cases, come in in extremis and, as you've said, that's much more difficult and

12:22

time-consuming to manage as compared with addressing their needs in a more timely fashion before the emergency happens --

A. Yeah.

95 Q. Was there any active initiative to, if you like, keep an eye on those patients before it became an emergency, or were no such initiatives conceived? 12:23

A. I don't think there was any initiatives actively targeting them, although there were initiatives to -- sorry, on a global term. There were initiatives for patients who had a catheter in to be outsourced to the independent sector. So, "yes" to that part of the equation. So there was specific targets and, again, ad hoc. So, yes, there were some targets, but not -- there wasn't an active role in reviewing everybody. There's a problem there. Are you going to review somebody or are you going to see a new patient who also has an active problem? So they all have an active problem. The new patients being referred in and a review patient, they all... 12:24 12:24 12:25

96 Q. Yes. As you say in your statement, life within this Urology Department has, I think you say, always been -- your words -- "an uphill struggle" and "Change has been slow and underfunded" and that's set out in paragraph 76.1 of your statement. But I think within your statement it's only fair to point out that there had been positive developments. It's not all doom and gloom?! 12:25

A. Yeah!

97 Q. You say, if we go to paragraph 39 of your statement -- so it's WIT-51765. So you set out in paragraph 39 a number of, I suppose, the more significant developments which helped to modernise and, I suppose, make more proactive the Urology Service and exploited those valuable human resources that were available to you, particularly on the nursing side, but not exclusively so. In particular, you refer to the one-stop clinic principle. I'm not sure if I see it there -- yes, of course. And that's assisted with presumably bringing timely interventions and also quality interventions to patients in need? 12:27 12:27

A. Okay, now, this comes back to our Thorndale unit and our building a urology ambulatory unit. As I say, we had experience of this with the original ICATS service, which was a small building. You know, we needed the extra floor space. Again, appreciating our small numbers of team members, the importance of having them all under the one roof, making people's time efficient, having a doctor/nurse term available, rather than trying to go and find somebody -- you know, you're all in the one unit and you can ask a question quickly. It's taken time to get our nursing staff up, as you say, to a high standard from a CNS point of view -- before they would have helped out at a prostate clinic, and now the CNSs are doing the biopsies. But having the safety net of them being in the same arena and floor space as everybody else around, it made them feel safe that they were doing it, from their aspect. 12:28 12:28 12:29

And from our aspect as the clinician, we felt safe that we were nearby if they needed to ask us something.

So the one-stop clinic principle is the advanced version of the old ICATS service, in principle. So we were, again, trying to get the maximum from the people that were available, albeit small numbers, but getting them trained up to such a level that allows everybody else to do something else. So we were being on an initiative ourselves, telling the Trust this is a good way to go. Same as the Urologist of the Week -- the principle of that was to come out of sort of daytime work to be on call to do the ward round. It took a little bit of time to, maybe, persuade the Trust that the Urologist of the Week was a good idea because they didn't see clinical output! But the sell point there was if a consultant was doing the ward round, it was more efficient in bed turnover, for instance. So trying to make beds so that somebody else could come into it. 12:29 12:30 12:30 12:31

But coming back to the one-stop clinic here, it's that it's meant to be one stop. The person coming into the clinic is being seen by the team, which could be the consultant or the nurse, and in the Thorndale, as I said, there were two rooms; one was for urodynamics and flexible cystoscopies and the other room was an ultrasound room. So, on the day, the patient would be seen, would have an ultrasound, could have a flexible 12:31

cystoscopy, and investigations -- potentially see a nurse as well and for a follow-up. So there was a plan -- at some of the clinics, the patients could have had their TRUS prostate biopsies at the same sitting. So we were trying to be as efficient with the throughput as possible. 12:32

98 Q. Your statement also charts positively the developments around stone work, which, obviously, you have a particular interest in, so that Craigavon has emerged as the regional centre for ESWL stone therapies. 12:32

A. Yeah.

99 Q. And the particular importance of specialist nurses in that context?

A. Yes, again, I've run the stone service -- it opened September 11th, 1998, and when I arrived there was four 12:33 grey walls and a big box in the corner, and I said, "Right, here's what you want to do with this space." So the space was for our ESWL machine, but I had a clinical space where I ran a clinic at the same time. Again, it was a one-stop clinic right from the word go. 12:33 So, again, we had a clinic, a nurse, an ultrasonographer, and the principle ran well for the volume that we had originally.

As time went by, the volume increased and I realised 12:34 I wasn't keeping up to speed with the volume. So we embarked on a fresh start and looked at all the various aspects of a patient coming with stones all the way through, and we redesigned the process. Now,

again, that, for the first decade or so, was me, but with the investment of extra staff members, has been an absolute must. We have a staff grade for the service and a clinical nurse specialist all working in the system. So, as I say, we had taken the stone department apart and have sort of rebuilt the process, and now we have a stone MDT -- well, it's a stone meeting, to be precise, and it runs on a weekly basis. And all the patients -- where we had patients waiting weeks to be seen, now they're all discussed on a weekly basis. 12:34 12:35

There's always a bit of give and take in this in that my stone outpatients, to start with, it was patient in front of you, going through all the options on a verbal basis and the information -- the nurse was there, the radiographer was there, but it took so long. Whereas, now, to improve the thing, it's that our stone meeting is, basically, all the team discussing cases and the patients have a letter, basically, informing them. But it has speeded up the process. 12:35 12:36

100 Q. I suppose another development that one can see being explained through your statement is, I suppose, the expansion, and stones being one example, the expansion of the nursing expertise and the embracing of nursing within Urology Service -- perhaps it's the wrong word, but the greater professionalisation or expansion of nursing? 12:36

A. Yes. Taking two examples here, (1) is outpatients in

Thorndale, and (2) is at our stone meeting -- I've always had a staff nurse at the level -- a staff nurse at the stone meeting, but it was very much from a nursing perspective of dealing with the patient, doing bloods -- whereas, now, moving on with the higher grades from a CNS point of view is that a lot of review patients are coming back to our nurse-led clinic for a certain sort of level of stone follow-up, which then has given the consultant more time to spend on -- and, again, on a timely basis -- to get the patient seen of the more complex, the more sort of complex cases. 12:37 12:37

101 Q. You explain in your statement -- maybe, if we pick up WIT-51743 -- at 26.1, you describe an ethos within the Urology Service which has been to encourage nurse training in the advancement of their careers. And you go on at 26.2 to say that -- I suppose, an approximate distinction -- there are two groups of specialist nurses, one on the cancer side, the specialist cancer nurse, and, on the other side, a specialist urological nurse, with a little overlap, as you put it. In terms of your involvement or engagement on the cancer nurse side, you explain, if we just scroll down, at 26.3, that your own clinic for oncology patients -- and just to put a date on that, is that a clinic for oncology patients that you continue to maintain even after you cease to become a formal member of the MDT? 12:38 12:38 12:39

A. Yes. I have a review clinic -- well, it was Friday afternoon. And that review clinic -- my actual set-up is a new patient clinic. It's all new patients.

I have a stone patient list, all stones -- that's second. And the third was a review clinic. And my review clinic involved standard review patients. It had two to three urodynamics patients on it. And then there would be an oncology review component and also any, as my secretary calls it, protected slots for the oncology patients discussed at the MDT.

102 Q. Yes. And picking up on that within your statement -- so MDT on Thursday. If one of your patients is discussed, he or she will come to you on the Friday or perhaps the following Friday by the time you get correspondence out? 12:40

A. Yeah.

103 Q. It's the involvement of the cancer nurse specialist that we're interested in now -- 12:41

A. Oh, right.

104 Q. -- and you describe that here. If the oncology cancer nurse specialist was not available due to work rostering or leave, then a senior staff nurse took over this role. If the CNS was not available, the patients were given contact details and vice versa. And then you go on to say that with the employment of additional CNS staff in the recent years, there has been a significant improvement in the provision of oncology CNS to cover clinics. And the CNS would work in partnership with yourself and, if they are not physically in the room with you at the time of the consultation, then you specifically ask for their presence at the end of the consultation, and you 12:40 12:41

explain why.

What is the importance from your perspective in terms of practising this way with direct, I suppose, involvement of the CNS with the patient at the same time as consultation, if circumstances permit? 12:42

A. Yes, now, as I say, my clinic was on a Friday afternoon. The CNS cover wasn't full. And I had Nurse Campbell, who was a senior nurse sister in the Outpatients, and she would be running the clinic at the same time and, generally speaking, didn't have time to be in the room with me for the full consultation. But I found, actually, that this worked well because I had the opportunity to go over the patient's information twice. So I consulted with the patient and then, at the end of that procedure, I would have Dolores come into the room; I would introduce the patient/Dolores in the same way, and then I would say -- I would then go over the whole thing again with them, with both Dolores and the nurse -- so that's Dolores and the patient. So that gave the patient again a second synopsis of the situation. We would then give the appropriate patient pamphlet. There's a pamphlet that we gave to the prostate cancers where we wrote in the pamphlet what the score was, what the treatment plan would be. So that gave the patient a second synopsis of what we're trying to put across, and also then Dolores was in the wing of knowing what was going on and she would take a record of what was done and then would have time to 12:42 12:42 12:43 12:43 12:44

spend more holistic time with the patient outside of the room while I am on to the next patient.

105 Q. And just the other part of my question, in terms of the benefit or the importance of having specialist nursing involvement, what is that doing for you and what is it doing for the patient? 12:45

A. Well, while I'm putting across the doctor aspect to it, the nurse can back that up, but there is also the holistic aspect to their care. It gives the patient an opportunity to talk to a second individual -- 12:45 sometimes talking to the nurse rather than talking to the big doctor about something! So it gives the patient a little bit more time to ask a question. But I think it's very much the holistic angle to it. And, also, it's a bit like a lot of things, it's only when 12:46 you go out of the room that you think, oh, I should have asked that question, or said that.

So the nurse would give the patient the phone number and card, basically, of contact point with the specific 12:46 understanding that "Look, here's -- if you have any more questions, here's how you make early contact." And, as I say to patients, there's not such a thing as a silly question. It's probably the most important question to be asked all afternoon, because it's what 12:46 they don't understand and want to know a bit more about. Is that what you're asking?

106 Q. Yes. And if I could just broaden that out, is there an expectation -- and maybe it would be on an exceptional

basis, but is there an expectation that the nurse, the specialist nurse, would have the wherewithal to ensure that everything is being done, if you like, properly, perhaps in accordance with what the MDT had recommended and to ensure that choices are being fully explored and explained with the patient and maybe to put their hand up and say, you know, "Mr. Young, this perhaps needs done", and thereafter to ensure that the pathway to be pursued by the patient is being appropriately followed? 12:47

A. So there's two questions in that -- 12:47

107 Q. Yes.

A. First -- sorry, the first is: Has all the information been put across? Yes, I think there is an onus -- if the specialist nurse has been to the MDT and you know what the outcome of that's meant to be -- has that been 12:48 discussed? Yes. How can that be found out? That can be either in the room at the time of the full consultation, or, for instance, in my case, if they are not in the room, it is discussed at the summary of the -- at the end of the consultation. Sorry, that 12:48 would have been my practice. So, for instance, somebody who is coming in with prostate cancer and they have been offered either surgery or radiotherapy, you know, this would be said in front of the nurse "I have discussed with Mr. X and Y -- here's the information 12:49 leaflets to go with both of those", and "Mr. X may want to discuss a little bit more of this with you outside", and if there's any holistic care packages to add to this, that's what it is. So, yes, the CNS does have

the opportunity to -- or, well, should have the opportunity -- yeah, should have the opportunity to have known what was discussed, whether it is the complete conversation or has a good summary of it, then I think that's fine -- 12:49

108 Q. And a rather more pedestrian question -- sorry for cutting across you --

A. That's okay.

109 Q. Go on ahead. You finish.

A. Sorry, I forgot the second question! 12:50

110 Q. I think in the care pathway that followed, I think you've part answered it, that nurses do have a responsibility or at least an opportunity for input to ensure that the care packages are properly explained and are followed up? 12:50

A. Explained and followed up -- so, explained, as I say, so there are several pamphlets available for each condition. This is an opportunity to actually go through it with them afterwards. As far as follow-up is concerned, my understanding is that the CNS, you know, is at the end of a phone if the patient has something further to question. 12:50

111 Q. Back to my pedestrian question then, the nuts and bolts of moving from MDT to knowing that the patient is coming in to consultant with you, how is it choreographed that the nurse is at the door of your clinic to see the patient, whether in the room or after the consultation has taken place? Is there a formality to the allocation of the nurse or is it simply, as 12:51

you've explained -- I think you called her Dolores -- was the constant, was on duty at the same time, and an expectation developed?

A. The nurse would know the oncology patients attending the clinic. I mean, mine, it was a protected slot. So at a precise time spread out through the afternoon to give everybody enough time -- probably enough time to give the nurse time to discuss afterwards -- so mine had a protected slot. Now, I'm speaking for myself here. That was my practice because for the full afternoon, you know, I may have 10 to 12 patients with urodynamics reviews, but the oncology patients got a protected slot time and the nurse would have known the cases that were on the protected slot and, at the end of it, if they didn't, they were invited in for the -- so I always had the nurse in the room at some time discussing the case. 12:52 12:52 12:52

112 Q. Thank you for that.

A. Does that answer it?

113 Q. That's helpful. If I could bring you to TRA-05379, I'm drawing your attention to a comment that one of the Cancer Nurse Specialists, Kate O'Neill, made. So it's Q. 415. So this is in the context of prostate biopsy in relation to your practice. And it's not the context in which we just immediately discussed, which is coming to see you after the MDT. And what she says -- she's asked the question: 12:53 12:53

"Q. Was that just a little bit of resistance to nurses taking on that role or was it something else?"

And if I can just go straight to the point -- you can read the first few lines: 12:54

"So, my feeling for it at that time was it just took Mr. Young that wee bit longer to engage with it."

That's the CNS involvement with it. 12:54

"My way of assisting that process was to ensure that I audited the services that I was providing and presented those audits at either departmental meetings or patient safety meetings to ensure that my clinical work was robust and safe."

She goes on to say to the extent that there was -- it's the questioner who uses the word "resistance", I think, my learned junior -- 12:55

"Q. ...is it dissipated entirely?
A. Oh, it's gone and it didn't delay anybody..."

-- does that resonate with you, that there was a bit of 12:55 a slowness to engage with nursing on the prostate biopsy?

A. Oh, the word "resistant" is wrong. I have been very encouraging of nurses to be involved in all our

practices. If I can maybe go back even to the original ICAT service, the Department of Health asked me directly why am I asking for two CNSs when they are only offering one, and I said because the service needs two. I wish I had asked for four, but I said two! And the two ended up as Kate and Jenny, and they have stayed throughout. So, no, I -- and, again, the principle of having Thorndale I and Thorndale II, everybody under the same roof so that there's a safety net -- that if the nurse wants to ask the doctor something and the doctor wants the nurse involved in something, it's everybody is there. So there has been nurse education in this. I have been fully supportive of nurses getting involved in everything. 12:55 12:56

Now, prostate biopsies was fairly new. I don't do prostate biopsies. It's my colleagues have been doing it. And when this was set up, it was the one-stop clinic, so the other consultants may have done their prostate biopsies on those occasions but, for myself, and I think for Mr. O'Brien as well, who didn't do the biopsies, is that our radiology colleagues came in and did that. So I had no objections to the nurses taking on all of these roles; I just wanted to make sure that they felt safe doing it. So there's a distinct -- okay, there might have been an air of this coming across -- I just wanted to make sure that the nurses felt safe doing the procedure and were well supported in doing it. 12:56 12:57 12:57

114 Q. So if there was a perception of delay or slowness, you would explain it on the basis of building competency and confidence in the process?

A. Yes. Whether the biopsy was done by the clinical nurse specialist or the radiologist, I wasn't concerned. My concern was to make sure that they felt sort of comfortable doing it. And if that came across the way it's been put across here, then I apologise if it came across that way. But I have been very supportive throughout my time of clinical nurse specialists. We have, undoubtedly got an excellent benign side of the service. Jenny runs our urodynamics; I have been fully supportive of her doing that all on her own. And the flexible cystoscopies, Patricia now does on her own. You know, so I have been more than supportive of clinical nurse specialists taking on the role. So it may have been a perception at the time, but I just wanted to make sure that they felt safe. 12:58 12:58 12:59

115 Q. Could I eat into our lunch break just for another three or four minutes to close on nursing? 12:59

I hope you've had the opportunity of reading the root cause analysis reports resulting out of the nine SAIs that were raised for review of Dr. Hughes and Mr. Gilbert in 2020. One of the points that they focused on, and perhaps one of the more significant points, was that across the nine cases that they looked at, and they all involved Mr. O'Brien as the main practitioner, is that they found that in the nine 12:59

cases, none of them, none of the patients had access to a cancer nurse specialist. Did you have any sense that Mr. O'Brien's engagement with cancer nurse specialists differed from yours? You've described yours earlier as one of engagement where the nurse was available on every cancer case that came through your clinic.

A. Every MDT, not the reviews.

116 Q. Yes, every new diagnosis --

A. No, I wasn't aware. I hadn't heard.

117 Q. It's not something you ever discussed with him? 13:01

A. No, I didn't discuss that with Mr. O'Brien.

118 Q. In terms of the usage that should be made of cancer nurse specialists, was that ever the subject of discussion -- perhaps, reinforcement -- at departmental meetings? 13:01

A. Ehm...

119 Q. I'm not asking you about a specific meeting, I'm just asking you to cast your mind back -- or, in the alternative, was it not something that appeared as an issue of concern or controversy? 13:01

A. It wasn't raised, as far as I was concerned, at a departmental meeting.

120 Q. You have said at paragraph 26.6 of your statement, just for the Panel's note, that you considered that the nurses -- that the Specialist Nurses in Urology communicated effectively and efficiently. They could raise concerns with the consultant team without any feeling of being pressurised. Does it surprise you that no one came to you to raise any concerns about 13:02

Mr. O'Brien's practice with regard to specialist nursing?

A. I wasn't aware that there was an issue. Or it hadn't been raised to me.

121 Q. I put the question in that way knowing that Mr. O'Brien will have a different perspective. The perspective I'm putting to you is the one that emerged from the SAIs, for the avoidance of doubt. 13:03

A. Yeah.

122 Q. But, again, across your colleagues in Urology, amongst the consultants this wasn't an issue that arose? To put it simply, was it your expectation that everybody would see the benefit of engaging with the cancer nurse specialists? 13:03

A. Absolute assumption that it was important. I mean, when the NICaN was set up at the beginning, when there was a review statement of this made in 2014 -- I don't know the precise date of the document -- there was clear information there to note the importance of the Clinical Nurse Specialist in the role of the cancer care and their involvement, both on a holistic basis as well as... 13:03 13:04

123 Q. And, again, for the avoidance of doubt, and we're talking here about cases in 2019 and 2020, by that stage would resources or resource factors offer any explanation as to why nurses may not be used with particular patients emerging from MDT? 13:04

A. It would be the number of CNSs available.

I've mentioned already sort of Fridays I had a staff

nurse, as opposed to the full CNS. So the actual numbers of CNSs weren't at an adequate level to start with. There should have been more. There was -- my understanding is they had advertised for two posts that remained unfilled. I think it might have been an advertisement issue, or there might not have been the standard expected. I don't know exactly the reasons. But the fact was there was meant to be more CNSs employed, but they were inadequate in number for a variety of reasons. 13:05 13:06

124 Q. But, I suppose, if, for whatever reason, the nurse isn't available on the particular day or clinic, the important point would it be to ensure that there was contactability between the patient and whatever nurse it might be? 13:06

A. Yes. For instance, coming back to my scenario, is that Dolores would hand over the information to Kate to actually follow through. Is that what you're asking?

MR. WOLFE KC: Yes, indeed. Thank you for that. It is now ten past one. 13:07

CHAIR: I think we'll come back again then at ten past two, ladies and gentlemen. See you then.

THE INQUIRY THEN ADJOURNED FOR LUNCH 14:09

THE INQUIRY RESUMED, AS FOLLOWS, AFTER LUNCH

CHAIR: Thank you, everyone. Mr. Wolfe?

125 Q. MR. WOLFE KC: Good afternoon. I want to spend the next short while, Mr. Young, looking at the area of accountability and governance in broad terms, encompassing, I suppose, relationships and communication between different levels of management, and encompassing your role as clinical lead and how you saw that and how others may have saw that, and also looking at some of the tools of governance that you've dealt with in your statement, including audit, patient safety meeting, and issues around data and what could be understood from the data that the Trust routinely collected. 14:09 14:09 14:10

Now, let's start with some, I suppose, basic understandings. At page WIT-51763, if we could have that up, you discuss clinical governance. Clinical governance, you say, was overseen primarily by the Director of Acute Services and, in your time, that was Dr. Rankin. 14:10

"It was, for a short time, Mrs. Burns and Mrs. Gishkori, and the associated management team." 14:11

By that, did you mean assistant directors?

A. Yes.

126 Q. And:

"This would have been shadowed by the higher management structure and the associated medical directors."
What do you mean by that?

A. There is a medical channel, as I took it, as the Medical Director -- the AMDs and then the Clinical Directors. Then I saw running, maybe, in tandem to a degree, from an organisational point of view, is the Acute Services like Dr. Rankin, and then the associate member. 14:11

127 Q. When you refer to "clinical governance" -- and I sometimes think people say that word and use that phrase and it's a common understanding, but what do you mean by it? Is it a broad -- are you using it broadly?

A. It is a broad term. Sometimes it's hard just to put it in a complete nutshell, but it's how the organisation sort of runs itself, I suppose, and feels safe about what it's doing. 14:12

128 Q. So it's that area directed to patient safety?

A. Yes. 14:12

129 Q. Does it encompass, in your view, I suppose, how clinicians are supervised and held to account? Some people might refer to that -- Dr. Simpson, I think, refers to that as professional governance, but are you including that within this broad definition? 14:13

A. It's a broad term, yes.

130 Q. Yes. And we also see references to some of what I've called the tools of governance, such as M&M, data collection, SAI, Datix. They're all encompassed within

that, is that how you would think of it?
A. That's how I would think of it, yes.
131 Q. You go on here just to -- there's, perhaps, an answer to my question -- clinical governance, I think you're saying, would have encompassed the patient safety meeting, along with the medical lead for this meeting. The lead clinician role, you say, was: 14:13

"...service-driven and the assurance for governance responsibility would have been as with that of the other consultants." 14:14

You use the term, the active term "responsibility" and you're equating the lead clinician role in terms of responsibility for clinical governance as being the same as for other consultants -- as with other consultants? 14:14
A. Yes, I am taking it that the lead clinician is a fellow consultant working alongside his peers, his or her peers. 14:14
132 Q. At various places in your statement -- paragraph 37.3, for example:

"The lead clinician role was service-driven and the assurance for governance responsibility would have been as with that of other consultants." 14:15

Sorry, that's just what we have here.
A. Yeah.

133 Q. Another example:

"My role in clinical governance was as a doctor in the position of being a consultant. This involved mentoring junior staff and providing a continuous high standard of care for patients."

So that's paragraph 7.3 of your statement. Then paragraph 38.4:

"My specific governance role in the unit I regarded as maintaining the work schedule for the whole medical team and, as such, was operational. Assurance of governance was as a hospital consultant, but the responsibility of governance lay with management structure and the Medical Director's team."

So, again, you're placing yourself as having no additional responsibility for clinical governance as compared with your fellow consultants; is that fair? 14:16

A. I regarded my element of higher sort of governance and management to be at a low level in that sort of ranking of seniority that you've just raised. So I felt that I was, if I can maybe use the phrase, the captain of the team, potentially, but I was working alongside my peers and with them. I wasn't having a direct responsibility for them, and that's what I was trying to get across. So I'm working as a doctor, I'm working as a consultant, working alongside my colleagues.

I may have been the one to try to gel the situation as part of the team, maybe.

134 Q. Let me put something else that you said and see if this underscores the point that you're making. If we go to paragraph 55.9, which you'll find at WIT-51790, you say at this point that: 14:17

"The Medical Director system from 2007 onwards with regards to my role as lead clinician was generally one directional. If there was an issue, the Medical Director would liaise with me directly or more likely through the Acute Service Leads. This was infrequent with specific reference to urology. The Medical Director's office does, however, issue general patient safety documents on a frequent basis and the principle of 'office door was always open' applied if a physician wanted a conversation. As lead clinician, if I noted a governance issue, it would be raised first with the Head of Service and/or Director of Acute Services of the time." 14:18 14:18

Does that last sentence help us to understand your words as "captain of the team" or, perhaps, first among equals, you did perceive of the role as having one to communicate to, for example, Mrs. Corrigan or to a clinical director if you saw a governance issue arise that needed attended to? 14:19

A. Yes, that would have been my first port of call.

135 Q. So is that over and above the responsibility of a, if

you like, run-of-the-mill consultant -- if there is such a thing -- it's hard to imagine!

A. Don't say that!

136 Q. No, strike that from the record! So you are sitting above the normal fray, are you not? 14:19

A. I agree the head is above the parapet a little bit on that front, yes.

137 Q. Let me put some other perspectives to you and you can tell me if you think they fit. Richard Wright was the Medical Director from the second half of 2015, taking 14:20 over from Dr. Wilson -- sorry, Dr. Simpson. If we go to WIT-17857 at paragraph 31.1, and he explains his role. He was the Executive Director primarily responsible for clinical governance matters as they related to doctors. And he explains the blurring of 14:21 the boundaries with the operational or the service side in that in the case of Mrs. Gishkori.

He goes on to say that the role of responsibility for clinical governance was delegated through the line 14:21 leadership structure to the Associate Medical Director, through the two Surgical Clinical Directors, then through to the Urology team, and, finally, to consultants and other medical staff, including trainees. There was also a shared governance 14:21 responsibility through the Associate Medical Director team across the specialities, the Trust specialities --

CHAIR: I think you've left out the most important word there Mr. Wolfe, it was the - team lead.

MR. WOLFE KC: Yes, sorry, I appreciate that, and thank you. So he's making the point -- I've left out the most important word -- so he's making the point that he saw the clinical lead or the team lead role as part of this supportive arrangements delegated from him through this chain of command, which included your post. Is that an acceptable way of viewing it?

A. That is an acceptable way of doing it, but if I can maybe add to that, I was not instructed through a job plan or anything what was actually required of a clinical lead. I've subsequently read it and it says it's a taster for entering into a sort of management role. So I do accept that if you are the lead, that there is slightly more involved in that than just being a consultant. 14:22 14:22 14:23

138 Q. I think the document to which you allude in terms of it being I think you said a taster role --

A. Well, apparently, it's a taster role if you wish to take it further along...

139 Q. Let's just look at that in context. The document you're alluding to is the Medical Directorate Structures. We have it as a draft document and it's WIT-55855. So we have this document and if we could scroll in to -- just open it -- go down seven pages, please, to 6-2 in the sequence. 14:23 14:24

I wonder, Chair, is it going to be possible to turn the heat off? Maybe not? It's extremely hot where I'm standing.

CHAIR: Mr. Murphy, would you, maybe, nip into the office, please, and see if that can be done remotely or if someone needs to come in to do it?

140 Q. MR. WOLFE KC: So, within this document, there's a reference to the speciality lead. You make the point "I've never received a job description" and we certainly haven't seen one for the role of speciality lead. And the nature and scope of the post is sketched out here. It is a post required to bolster medical management capacity and ensure coordination within a specialty. So implicit in that -- "bolstering medical management" seems to mean adding support to the medical management? 14:25 14:25

A. Yes.

141 Q. On accountability, you will account managerially and professionally to the clinical director of the division. At various points that was Mr. Brown, Mr. McNaboe, and Ms. Hall. 14:26

A. Mr. Hall.

142 Q. Mr. Hall? 14:26

A. Mr. Hall. It was Mr. Hall and Mr. Weir.

143 Q. You used the phrase earlier:

"The post of specialty lead is a taster role for those who want to try medical management out. The post may become a stepping stone to a wider management role or may prove to be as much as the post-holder wishes to take on for a longer period." 14:26

So you stopped at that rung in the ladder. You didn't use it as a stepping stone to elsewhere --

A. Correct. I didn't want to climb up the management level.

144 Q. Yes. In terms of the role, were you remunerated for it? 14:27

A. Yes. I was given 0.5 PA.

145 Q. Did that adequately reflect the time that you devoted to the responsibilities of the role?

A. I don't think so. 14:27

146 Q. Were you supported administratively or otherwise in the role?

A. My secretary did any typing that I needed.

147 Q. In terms of, if you like, training for the role, support in that direction, did you ever receive any specialty lead specific training? 14:28

A. No. I trained myself and to what I thought was needed.

148 Q. Were you given any guidance as to what might be needed?

A. No. But I also wasn't told that I was doing something wrong, if you know what I mean -- if I was going up a wrong pathway, that's what I'm trying to say. 14:28

149 Q. Over the years -- and it was 20, approximately, years for which you held the role --

A. Yes.

150 Q. -- did anybody at any point press the pause button with you and say "You're doing this particularly well, but you're not doing this particularly well"? Any meetings of an appraisal-type nature focusing on specialty lead? 14:28

A. No.

151 Q. Just going back to some of the other perspectives on it, let me bring you to Mr. Simpson -- and I think I've referred the Panel to the reference and I don't think I need to bring it up, WIT-25712 -- at paragraph 25.1 of his statement, he said the Associate Medical Director, with the support of the two clinical directors and the lead clinician had particular responsibility for clinical governance. Maybe that puts it further than you would like? 14:29

A. It is. That's the Medical Director's perspective of what I did. 14:30

152 Q. Mr. Mackle, bringing his statement up, WIT-11749, at paragraph 42 he talks about the difficulties and the pressures he found in the AMD role, and he goes on to say: 14:30

"Heather Trouton, the acute directors, and myself relied on the assurance of Michael Young and Robin Brown that there were no clinical concerns. The current system is such that an AMD has to rely on the CD and lead clinician to supply accurate assessments on the clinicians in their team." 14:31

My words, not his. But, in a sense, he's suggesting that to enable him to do his job properly in this delegated chain, he needs you and the Clinical Director to be his eyes and ears. Is that another reasonable perspective? 14:31

A. I think that is very, very reasonable. Often, the lead

clinician will be the first of the team that you're going to go and speak to. I think that's fair.

153 Q. On the Clinical Director side, Mr. Brown, WIT-17527, at 25.1 he refers to: 14:32

"Day-to-day clinical management would have been carried out by the lead clinician, Michael Young, and any other team member to whom they delegated tasks, such as the MDM lead." 14:32

And he goes on to say:

"During my tenure, Michael Young would have reported to me or Eamonn Mackle..." 14:32

-- he uses the term "reported" --

"...to describe lines of communication rather than the exchange of actual reports." 14:32

And he doesn't recall any concerns raised by you. So, again, that phrase "day-to-day clinical management" carried out by you, is that another adequate characterisation of the role?

A. The role was the day-to-day running of the unit. I, maybe, come back to the rota that I would have mentioned earlier. I would have known where everybody was meant to be. If somebody rang in sick, I then would be on the ground to try to move the cards around 14:33

the table to get that sort of clinical activity covered. And this day-to-day -- so the clinical management was very much inter-related to the Head of Service, Martina Corrigan, to make the unit run on a day-to-day basis. 14:34

154 Q. You illustrate the point by reference to a very practical activity --

A. Yes.

155 Q. -- ensuring that the service can run. But did the day-to-day clinical management, was it broader than that? Was it ensuring that the clinicians, if you like, were behaving themselves or, if they had any difficulties, sussing that out and reporting it perhaps upwards? 14:34

A. Yes. It primarily related to our junior staff or the likes of staff grades, if there were issues. 14:34

156 Q. But did it not apply also -- we'll look at some of the examples later this afternoon, but did it apply also, in your view, to your peers?

A. I found the role of -- I found that part hard. As a lead clinician, the non-interpersonal ways of running a unit I found very easy. I felt it hard to deal with a peer-to-peer issue because I felt I was one of the same team. So any comments I would be making on that front would have been as a consultant-to-consultant sort of level. 14:35 14:35

157 Q. Yes, as opposed to you being a manager --

A. Yes.

158 Q. -- with authority?

A. Ehm, I take the word, that last word, "authority" -- I agree with being captain of the team, if you want --

159 Q. Sorry, somebody coughed and I lost the word --

A. If you are being the captain of the team, it is putting you at a slightly higher sort of level, but you are working with the team. So any report on that line would have been as a consultant. I do accept that this role had a slightly higher level than just a consultant, right, I do accept that. But it is the word in the ear of Mr. Brown and Mr. Mackle is that the lead may be the person they do come to first. 14:36 14:36

160 Q. Yes. I wonder is your slight awkwardness or discomfort around this reflected in something Mrs. Corrigan has said, if I can ask your comments on this -- if we go to WIT-26304 and at I think it's paragraph E, she's reflecting some learning arising out of, if you like, all of this. She says: 14:37

"In my opinion, another area that I consider should be taken into account with respect to learning is the need for a clear management structure of medical staff. For clinical staff, they need to know who this is and what authority they have as their accountable..." 14:37

-- and I think that should say "manager". 14:38

"It is my observation that there wasn't a clear line of accountability of management while I was in post. So whilst the consultants were directly accountable to

their responsible officer, the Medical Director, I believe that they were unsure who was responsible for managing them on a day-to-day basis. Whilst there was a clinical lead, Mr. Young, and whilst I believe it was understood that he should be managing the rest of the urological consultants, Mr. Young never had an actual job description outlining what this should entail and, from my recollection, only got 0.5 of a PA to be the clinical lead, so I don't believe that he ever felt that this was his role, although this would be a matter best addressed by him."

14:38

14:38

And here we are! It's set up for your comment, I think. She's speaking in tolerably clear terms, but, to paraphrase, is she echoing something of what you've just recently said, that, really, you didn't accept that you were the manager of these collection of Consultant Urologists in the kind of sense that she's describing -- that is with authority, telling them to pull their socks up if they needed to pull their socks up, and...

14:39

14:39

A. That's spot on. It's a small group. It's a small team. It's very important to get on to make the thing -- to make the work gel, to make the whole as a unit gel. So it's hard if it's -- if you're put on the spot. If someone needs to be put on the spot, that's fairly obvious, but, you know, I felt a bit pressurised on that front and I thought it was an unfair ask, if you want to put it that way.

14:40

161 Q. Yes. Plainly, you took the role on in or about 2000, give or take?
A. Yes.
162 Q. It's in much different-looking shape than it was in 2014 when you have five or six consultants, albeit for a short time, as we discussed earlier. 14:40
A. Yeah.
163 Q. Do you feel that the expectations that came with the job changed throughout that time?
A. Well, like most things, they change as they move on. I mean, I saw the role as a service-driven, sort of organisational job. I would have represented the unit at such things as our THUGS Committee -- that's our theatre users group! So I would have represented our unit for that to report to the Committee on what we wanted from Urology, and maybe backwards from that Committee to the rest of the team. I saw my role as leading on if there was any sort of major sort of project to get through, that would have been -- for instance, actually setting up the ICATS service on the 2009 process of how we're going to get this into the unit; I sought -- there was the saline resectoscope issue -- I sort of took charge in trying to process that, to make it happen, and maybe facilitated the departmental meetings. But, again, that was trying to get people to get round the table. And, again, I might have sort of managed the staff grades in a little bit more detail, albeit that the staff grades contract, their next in charge was actually the CD, I believe; it 14:41 14:41 14:42 14:42

wasn't me.

164 Q. Yes.

A. Although I took control of it.

165 Q. Yes. And, in many ways, your pre-empting -- I'm not criticising you, by any means -- some of the bigger ticket items we'll explore through your evidence to see how they managed and to see how they both reflected on your role and how what they say about, I suppose, governance in general. 14:43

14:43

Just before I leave what Ms. Corrigan has said, and it's up on the screen, she adds the sentence that she felt or she feels it was unfair, in any event, to have peers attempting to manage peers, as these were their colleagues and it was hard to hold them to account when they were of the same grade. So I think that's echoing at the very heart of your discomfiture -- 14:44

A. Yeah.

166 Q. Yes, you were happy, if you like, to take on activity-based projects -- the resectoscope being an example we'll, maybe, look at later for other reasons, but much more difficult to grapple with under-performance, for example, on the part of a peer, and that's not something you felt you should have been asked to do and you weren't comfortable doing it when you were asked? 14:44 14:45

A. I wasn't comfortable, yeah. I think a lot of these issues are, you know, at a higher level to try to sort.

167 Q. And it would appear, reading between the lines of

Mrs. Corrigan's statement, albeit that is a matter for the Panel to read between the lines, but she would appear to have recognised your discomfiture. But it didn't, as we will shortly see, prevent or alleviate the demands that came your way to address issues, particularly in the context of Mr. O'Brien, isn't that right? You were expected to roll your sleeves up and come up with, if you like, short-term solutions or immediate solutions? 14:45

A. I was asked, yes. 14:46

168 Q. Yes. I think just to bring you back just finally on this area, I think this probably encapsulates what you thought of the role. If we go to WIT-51780, at 49.1 you say: 14:46

"The lead clinician role is service-based and did not have a direct responsibility for other consultants other than a working relationship alongside them as colleagues on a daily basis and offering support and advice." 14:47

So the distinction I think you're drawing there is between some of the service-based activities -- getting the rota right; if there's a new development such as resectoscope, let's get that pushed through -- but when it comes to direct responsibility for what consultants are doing in their day-to-day practice, I will speak to them, I will offer advice, I will convey messages from wider management, but it's not my direct responsibility 14:47

to manage them -- is that it?

A. I feel that's right.

169 Q. In terms of your own accountability as -- perhaps, both as a consultant and as a clinical lead, on day-to-day matters you explained you reported to Mrs. Corrigan? 14:48

A. Yes. This would have been from a medical perspective, or her asking me about operational issues that she needed addressed from a medical perspective.

170 Q. In terms of relations between consultants and operational or service managers, you've said that, 14:48 following the regional review in 2009, the medical and administrative managerial structure appeared more structured, as compared to what went before.

A. Yes.

171 Q. This is paragraph 32.1 of your statement. What did 14:49 you mean by that, by "more structured", and is that a good thing?

A. It's a good thing. Before the change between the Hospital and the Trust, the system was the Chief Executive, Mr. Templeton, who had his office on the top 14:49 floor, and then there was the Medical Director below that, and that ran the Hospital. And then when it became the Trust, then there was increased -- so, levels. The Trust was getting bigger, it needed more hands to look after it. And that was my understanding 14:50 of the addition of the extra levels.

172 Q. How did that structure assist you, either -- that greater structuring, how did that assist you as either a consultant or wearing your clinical lead hat?

A. I must say I had a very good relationship with Mr. Templeton, who was the Chief Executive. We did have our times together and arguments about how the service should go, but that was a direct conversation to the top brass, shall we say. 14:50

With the new introduction, then that was to the Acute Service lead, and then the likes of the AMD would have been more of where you took the high-end points to to get dealt with, as we did with going through the 2009 14:51 service review. And then on a day-to-day basis of levels, it was -- my first port of call was the Head of Service. And if that then needed to -- if she needed to take it higher, then she would have taken it to the Clinical Director and the AMD level. 14:51

173 Q. Yes. So you say in your statement that since 2009 -- this is paragraph 54.2 -- maybe bring it up on the screen, please -- it's WIT-51785 -- and at 54.2, you say: 14:52

"Following the 2009 review, I felt my role as lead clinical was very much supported by the immediate line management system of heads of service and clinical directors covering urology. They had been supportive and deeply involved in all the projects our department 14:52 have put forward."

I think you allude to a bit of pain before things settle down, and on several occasions in your witness

statement you refer to a difficult period in your engagement with Dr. Rankin in trying to implement the various aspects of the regional review.

A. Yes. But I think you were asking what was the sort of chain of command that I would have gone through to take something forward, and that's exactly what, yeah. 14:53

174 Q. Yes. So just reflecting on two points, the first point is that, post 2009, there was an unsettling period that you reflect in your statement in terms of relationships with Dr. Rankin, I think, primarily, were you felt she wasn't taking on board your suggestions for the good of the Urology Service. And I get the sense that it was a rather bruising period? 14:53

A. We were all trying to make our point.

175 Q. Yes. 14:53

A. But there was open -- there was open dialogue. I mean, it's not that everybody went quiet. I mean, it was a very constructive approach to the whole thing. I mean, the 2009 review had as -- I think either 21 or 23 things to actually get through, and we sort of worked -- we worked through those. Some were easy, some weren't. We were trying to put across our case. The Trust was following the lines of the Department of Health and used the -- the Department of Health had a very fixed view on how many patients that they wanted you to see at a clinician, and the Boyce document from 2000, ten years before, had a structure to it. In the meantime, we had the ICAT service. We had seen that the outpatient sort of set-up for a consultant, they 14:54 14:54

were seeing the more complex cases and, therefore, it took slightly longer to get through. As part of the review they said, "Look, go back and sort all of this out that suits your arena." Now, the arena for Belfast is -- it's one big city. We live in a rural area, so we have Outreach Clinics. Travelling to the southwest, for me that was 150 miles round-turn drive in a day. So all of those things had to be incorporated into the equation. 14:55

Our sort of day surgery unit, it wasn't a day surgery unit, it was a morning surgery unit. The patients had to go out at lunchtime for the afternoon patients coming in. It didn't have X-ray screening -- you know, so we couldn't take our stone kit. So there was lots of things that maybe fitted one unit that doesn't fit the other. But as part of our understanding of what they were trying to tell us is "Go make it fit", and maybe that's where Dr. Rankin and I -- we had conversations, if you want to put it that way! 14:56 14:56

176 Q. I think just for completeness, because it's on the record and you may feel the need to comment on it -- if you don't feel the need to say much more than you've already said, then so be it. Mr. Mackle, who was part of those conversations, alongside Dr. Rankin, you on the other side of the table, perhaps Mr. O'Brien and other colleagues, he says at paragraph 64 of his statement: 14:57

"A long, drawn out process. We were met by three urologists with a lot of suspicion..."

-- "objective", I think, is the word he used --

14:57

"...obfuscation and obstruction to the process and to the aims of the project."

Your response might be what you've already said, that you had a particular understanding of the service that was required for your own locality? 14:57

A. We had our ideas of where it was going to go. We knew that we needed a new sort of Thorndale unit. I think I said earlier that when I knew we were going to get the new floor space, I knew we were heading in the right direction. I can understand sort of Mr. Mackle's comments. 14:58

It didn't help our side from a perspective is that the year before all of this, or within the same year, our Urology ward was disbanded. Now, we took a bit of grievance to that, but I understand that the Trust needed to cut beds. I think this was a financial reason. I don't know fully behind it, but it often -- I'm sure that's exactly what it is, it was a financial reason that the Trust were told to cut X amount of beds, and it just happened to be ours. And in the middle of this then, we were having a Urology review of trying to expand beds -- trying to sort of gel the 14:58 14:58

Urology Unit. So there was a wee bit of give and take here.

But I think, maybe, some of us were a little bit more vocal than others. I know it's saying here that he's saying "us" being as three, but certainly I think it's reasonable to say that Mr. O'Brien wasn't so keen on all the changes that were coming. I did agree with him, because we had to agree as a unit of where we were wanting to go. But I think some were more akin to it than others. Is that enough? 14:59 14:59

177 Q. Thank you. And the second point which you were going to major on and which I had asked you, in fairness, was in terms of, post 2009, you say you felt very much supported by immediate line management, and here you site the Head of Service, Mrs. Corrigan, and the various clinical directors with whom you worked who covered Urology. In -- 15:00

A. Could I add to that?

178 Q. Yes. 15:00

A. I know I had my initial grievances with the likes of Dr. Rankin, but I know that she was trying to get us over the line to get an efficient, effective approach, and I do understand her role and was, indeed, very grateful that she stuck with us, shall we say, and did get that. But, yes. 15:01

179 Q. In terms of the support that you felt from the immediate line management -- Mrs. Corrigan, Mr. Brown, for example -- where was that or how was that

manifested? In what kinds of activities did you feel, as the clinical lead, that you were receiving this support?

A. Mr. Brown was a surgeon in Daisy Hill who had a urology interest, so he was maybe a bit off site, but he would 15:01
certainly come up on a regular basis. It might have been once a week or -- well, he probably came up a little more frequently than that, but as far as interaction... We could chat easily. He did the urology in Daisy Hill, so he would interlink with us on 15:02
a sort of clinical ground, as well as from an administrative point of view. The interaction with Mrs. Corrigan was -- her office was on the top floor and was easily accessible. It would have been phone calls: "Can you help with this?". There was a lot 15:02
more done on a verbal basis than necessarily going on to the computer.

180 Q. I'm interested in, as you seem to be describing, the helpful and constructive dynamics of these relationships because -- and I know it is likely to 15:02
have been a very small part of the history of this urology service, but when we go on to look at how triage was managed and the problems with that, how patient charts at home was managed, how the dictation issue was managed, these are the people, these are the 15:03
managers who are part of the conversation with you, particularly Mrs. Corrigan. And given what you say are the constructive and helpful and supportive attributes of these people, we might bear that in mind when trying

to search for explanations as to why the issues that I've just mentioned were not resolved as readily as people might have liked. So we'll come to that in due course.

Can I just ask you about be how the Urology Service did its business in terms of communication and working through issues. There was a monthly rota meeting and there was a weekly departmental meeting. The departmental meeting was held on a Thursday lunchtime or thereabouts, is that correct? 15:04

A. Yes.

181 Q. And you've explained that these meetings -- this is paragraph 38.3 of your statement:

"These meetings were designed to give team members an opportunity to discuss and raise any point they wished. These meetings may have had an agenda but often would include pressing issues a consultant would like discussed. They were often not minuted but it was an opportunity for one of the team with the Head of Service to take issues forward." 15:04 15:05

I get a sense from what you're saying that during Mrs. Corrigan's era, they were not as well structured as they are now under Mrs. Clayton. And I don't know whether that was intended as a criticism, but just as a -- maybe just as a reflection of a style of approach? 15:05

A. It's a fair comment, yes.

182 Q. And in terms of these meetings, you've said, for example, that you used it as a portal to discuss a range of issues, and we'll see later including triage. But did they ultimately fizzle out in terms of the commitment of consultants to attend them? 15:06

A. Ehm, "Yes" is a very straight answer to that. But maybe to expand on it, if possible, Thursday mornings were defined as a non -- as a clinical time -- we used to have an X-ray conference, ward round, and then in the afternoon there was the MDT. So, in theory, 15:06 everybody should have been on site on a Thursday lunch time. We all had our own sort of clinical things and we could have been like sort of ships in the night during the week, but, you know, Thursday lunchtime seemed a good time to have a meeting, as we did once 15:07 a month for the rota meeting.

So, on a monthly basis, there was a rota meeting, and then the other three weeks it was a departmental meeting. The departmental meeting would have been in, 15:07 like -- like, school term-time, if you want to call it that way -- we would run for a couple of months and then have a break. So that was the set up. So that was the opportunity that I was trying to set aside for people to come round the table. 15:07

Now, the departmental meeting had success on occasions, and fell apart on others. The successful occasions were when there was a Trust issue coming to us to try

to sort -- for instance, the setting up of the ICATS and the saline. So if there was a Trust issue -- or especially the 2009 review, you know, that was well attended whenever we got our nurses around the table and sorting out the care pathway. So that was a good opportunity. 15:08

The third set is where we, as a urology department, were wanting to address something that we would put to the Trust, then those, we found, weren't as productive because they didn't have an outcome. The only -- for instance, the -- well, maybe the good ones were the topics on sort of paediatrics and we had discussions on mitomycin -- that's drug treatment into the bladder. So the Trust wanted us to go to set up a paediatric unit in Daisy Hill, so, you know, that was a structured meeting with the team around the table. There were some had been trained in paediatrics and others weren't. So that team went off to try to sort it out. 15:08 15:09

But we all sort of realised as time went out that, you know, our output from it wasn't particularly productive and some members didn't attend as well as they should have. But the point about Thursday lunchtime was that they were meant to be free. That's what I'm getting at. 15:09 15:10

183 Q. You sent out an e-mail in November 2019 reflecting that you had expressed concerns about the lack of departmental meetings. You said:

"We haven't met properly in about a year."

Mr. Glackin, in his evidence to us, reflects that, quite often, he found himself and yourself sitting, 15:10
waiting, waiting, and waiting for colleagues to attend, and here he names Mr. O'Brien, Mr. Haynes, and Mr. O'Donoghue as either poor attenders or late attenders. And although you did your best to lead the Urology team, he reflects that due to the number of 15:11
fronts on which the Service was failing to deliver, he said it was difficult to achieve a consensus without the engagement of colleagues. Is that fair comment?

A. That's a fair comment.

184 Q. Can you explain this malaise that it fell into? 15:11

A. I think we spent time -- we did spend time talking about topics, but getting them over the line eventually was hard -- again, unless there was a specific agenda of the Trust, and I've mentioned two there.

185 Q. Yes. We've discussed earlier your sense of discomfort 15:11
if cast in the role of having to challenge peers about shortcomings or perceived shortcomings in their practice. Assumedly, this would be the wrong kind of meeting to do that directly?

A. I think so, yes. And although we -- well, it was 15:12
a good opportunity to get people around the table, rather than having individual conversations. I think an individual conversation can be more challenging than if you had a group of people together in a room. It

was the opportunity to have an open conversation amongst colleagues. So if there was something that was annoying us, you know, that's what we would do.
I mean, an example of a challenge there would have related to Mr. O'Brien's sort of letter-writing and triage, I must confess. That was brought up as a team talking together rather than just one person talking, you know, one-to-one. It's, maybe, a team approach to trying to address an issue. So that might be an example of informally meeting around a table trying to sort a problem out, or at least talking about it or bringing it out into the open. 15:13 15:13

186 Q. So what you're saying is in the context of triage, and we can see from some of the material that's been put into the Inquiry that -- including your witness statement -- that around triage there were conversations -- you can tell me how frequently -- about seeking to define what was meant or what was expected by advanced triage, and we'll look at that specifically a little later -- 15:14 15:14

A. Yes.

187 Q. But is that the kind of thing that you're referring to?

A. That's exactly the thing I'm trying to refer to. And I'm trying to think of another example of where one person did something or two people did something and the other two or three didn't. Anyway, I have to think about that one. 15:14

188 Q. Okay. Just a few other items in, I suppose, the broad governance arena. You were an attendee, as was

expected of you, and I suppose all of the consultants and medical staff, of the Patient Safety meeting. It was led, certainly from 2015, by Mr. Glackin?

A. Yes.

189 Q. You reflect, I think, in positive terms that -- this is paragraph 29.4 of your statement -- that: 15:15

"During the last ten years, these meetings have been mainly involving the individual units, with a quarterly joint meeting." 15:15

So individual units must mean the Urology Department, and then there was a bigger quarterly meeting for surgery?

A. Yes. 15:15

190 Q.

"This approach allowed detailed, appropriate, focused discussions on individual unit issues and significant learning points from other departments could be distributed via the joint meeting." 15:16

So in terms of the individual or specific urology meeting -- led, as I say, by Mr. Glackin and subsequently led by Mr. O'Donoghue -- what was the virtue or merit of that meeting in governance terms? 15:16

A. You were discussing patient care. It was -- at the beginning, there was very much a focus on mortality cases -- maybe not so much on the morbidity angle -- and we would have had audits. Now, from a mortality

perspective in urology -- and, I mean, I think it was a hospital thing, that you had to have a mortality meeting, but most of the urology deaths were relating to sort of hospice type -- it was end of care, it wasn't particularly anything coming up that was unusual, shall we say. Obviously, there were some, but, I mean, they were addressed. It has progressed that we're now discussing the morbidity that's going on in much more detail and much more time. That has proved to be much more productive. 15:17

How was that picked up? At the beginning, we used to have a ward book that we'd write cases down. With time, you might tend to forget what they were, so if they were written down in the book we could come back to it. And the other major one to the Patient Safety meeting would have been the likes of audits. We probably could have been doing more audits. The audits were done by the registrars because, as part of their training, they would have had to have done one or two audits per year. So that's what they did. So if you only have two registrars, you're going to get two audits -- in theory. That's a broad term to the occasion. We would have had more done but that was -- that's what the Patient Safety meeting... 15:18 15:19

An observation that I've made in the last couple of months is that it's all been discussed the other way round. We, for instance, our last audit meeting

we had, we started with the audits performed. Then we discussed the morbidity, and that took most of the meeting. And we discussed the mortalities at the end, which all sailed through. And that was probably one of the best audit meetings from our department that we'd been at. There was very open chat. The consultants were there, the registrars were there, and the nursing staff were all involved. And instead of getting tired at the end of the meeting, we had the interesting stuff at the beginning! 15:19 15:20

191 Q. There was a sense reflected primarily, I think, by Mr. Glackin in his evidence, but even going back before that to those in the Acute Directorate on the service side I suppose bemoaning the reduction in support and resource for audit because of probably around 2015/'16 and the years around that, the Trust, it was suggested, was having to find resource savings, and support for audit and quality assurance were the casualties, or casualties amongst others. Is that a perspective that you recognise? 15:20 15:21

A. Yes. It's much more structured and supported now by audit teams. Before, my understanding is that you ran the show yourself, practically.

192 Q. Yes. In terms of the connection between the issues discussed at a Patient Safety meeting and the reform or remediation steps that are required around the issue being discussed -- take, for example, and we'll come to your audit which you conducted with Mr. Hiew -- is that how you pronounce him? -- in relation to stone 15:21

management and stenting, that issue, just to take that example, was on the agenda -- the issue of stent management was on the agenda across multiple M&M or Patient Safety meetings over several years, generated by Datix or incident reports and the occasional Serious Adverse Incident. 15:22

So the issue is known, widely known among the consultant body, and coming back and coming back and coming back, but nothing, it appears, being generated on the other side of the line in terms of solutions. I take that as by way of an example that we could broaden to other issues or incidents. Was there a disconnect between, if you like, the talking shop -- we recognise the problem -- and then the ability to provide a solution? 15:22 15:23

A. I feel that the Patient Safety meeting had a better output/outcome potential to address an issue rather than our departmental meeting, for instance. So, yes, instead of talking, having the audit to back up what you are trying to put across was good, and it was the Patient Safety meeting that had that opportunity. So it was the opportunity of collecting the facts. Now, you can take the facts to the Trust to say "Look, here's the information, here's what we have to do" -- it is then up to the higher management to try to make it all happen. It's possible to try to drive it but, you know -- yeah, it's always good to have a solution in mind to help the Trust take it further. 15:23 15:24

193 Q. Can you think of, in governance terms, how that gap, if it is a gap, can be addressed or improved upon by reference to any clinical example, or can you suggest a clinical example where the deficit in practice or the shortcoming has made its way from discussion and awareness-building at the Patient Safety meeting across the line into the practical action? 15:25

A. Can I use my stone example?

194 Q. Yes?

A. Okay. There are several types of stents -- (1) you leave in overnight, (2) is a stent on strings, (3) will be the stent that's been left in for a period of a couple of weeks to let something settle down, and (4) is a stent that's put in because you want to bring the patient back to do further work. Having realised that patients were having difficulty getting back to have their stents taken out within that month, there are stents that have strings on them now and the string comes to the exterior. So instead of having to come back and use a cystoscopy slot to take the stent out, these patients with strings come back between five and seven -- well, we try to aim for five days after the procedure. Patients often take out their own stent and may send us a photograph to prove that they have pulled it out. But having identified that patients were having difficulty getting back, the stents on strings helped them get back within the week. 15:25 15:26 15:26 15:27

195 Q. So what was the process -- maybe call it a governance process that gets you from discussing the problem,

presenting the problem at Patient Safety meeting, to that -- presumably, that isn't a solution for every patient, but it helps,

A. No, it's not, but it helps. Well, we, as a unit, had to find this is a problem, and we have a solution to it and the solution is that. 15:27

196 Q. Another aspect of the problem is for those patients who have had a stent installed without a string, there were a series of cases -- no doubt, you're aware of them -- for example, Patient 91 mentioned in the document in front of you, Patient 16, Patient 136, these were all stent cases. I suppose -- I'll give you those numbers again -- 16, 91, and 136 -- and perhaps the names don't all mean... None of them mean anything to you? 15:28

A. Mmm, just the one, I think. 15:29

197 Q. Patient 91 was a case where there was a number of factors in play, but the patient died post-operatively -- co-morbidities, but there was a delay in bringing him in to hospital for removal of the stent, and there was a failure to do an adequate pre-operation preparation in terms of a mid-stream urine test to test for infection. But an aspect of all of these cases is the -- we know that this patient has a stent; we know that he needs it removed to prevent risk of encrustation and potentially sepsis and those kinds of problems -- 15:29 15:30

A. Yes.

198 Q. But, as I say, a number of these cases where the patient isn't being managed to the removal slot at an

appropriate pace?

A. The appropriate -- yes. I will maybe take you to the fourth reason for having a stent in, and that is a stent that's in that needs inpatient care because there's something else that needs to be done -- you may need to repeat ureteroscopy, for instance. So that's a slightly different picture to, maybe going back to the last example, is we used to use a flexible -- well, we do use a flexible cystoscopy to take out the stent, so you need a slot on the flexible cystoscopy list and, as part of that outcome then, we tried to reserve a slot on the flexible cystoscopy list so that those patients could come back. So that was an outcome of the audit. 15:30 15:31

199 Q. Yes, your audit, I should say -- 15:31

A. Yes, but --

200 Q. Let me just introduce your audit. It's at TRU-396077. Sorry, I hope I'm not confusing things. I think just to reiterate and emphasise, the point I'm making to you is that in terms of the adequacy of a Patient Safety meeting in terms of a governance tool, we are seeing and we have observed seeing cases, some of which I've mentioned to you, using stents, as an example, coming into discussion in this forum. It oversimplifies it to say it's the same problem every time, but it's a species of the same problem, management of stents. And my question ultimately becomes if governance is to be more than a talking shop, it needs solutions to a problem that's oft 15:32 15:32

repeated in practice. And I hope you're going to tell me that your audit with Mr. Hiew, which was commissioned in 2018/2019 looked at this area, isn't that right?

A. Yes. It's looking at the stents that can be removed easily and on a day patient point of view. 15:33

201 Q. You looked at a cohort cases through 2017 and 2018 and then December 2018 to February 2019 and you came up with three proposals for change, I think. If we just briefly glance at those -- TRU-396090 -- so a checklist for stent removal on strings: 15:33

"Improved logistics in removing stents with flexible cystoscopies using a pooled list."

15:34

And the question:

"How can we improve stents at a realistic timeline?".

Was there an answer to the final question, which I suppose is at the core of our governance concern here? 15:34

A. The issue is getting a slot to take out -- to get out the stent. It needs an attendance at a day surgery list, which is already full of check cystoscopies for the likes of bladder cancer and other investigations. They've always tried to get as many onto a list as possible and if you leave one or two slots free, that becomes an under -- an observed under-utilisation of the slots. But, again, having the likes of this audit 15:34

done, it helps to prove that it is a necessary -- and from a volume perspective, it would be used. It is not just the odd case here and there.

202 Q. We've heard some evidence already from Mr. O'Donoghue about the use of Lagan Valley for an aspect of this work. Am I right in my recollection there? 15:35

A. Absolutely.

203 Q. Yes.

A. Again, it is finding the availability of an output agent and, undoubtedly the recent Lagan Valley day surgery has undoubtably revolutionised what we're doing. We were talking earlier this morning about lack of theatre space. You know, this is -- where we only had one theatre in Craigavon, this has been a major improvement. I know we can talk about COVID and how it has restricted activity, but certainly COVID has reinvented the wheel in terms of where we would be operating. I mean, it was maybe instrumental in getting us to move to Daisy Hill, the Health Minister engaging to get Lagan Valley as a day surgery unit -- a day surgery, all day -- it's an all day session. I said earlier this morning about our Craigavon day surgery, that it was only the morning. The patients had to go home. There was no opportunity to do any stone work. 15:36 15:36 15:37 15:37

So we've shifted a lot of inpatient work towards a day surgery arena so that these patients who are operated in the morning can stay all day and go home at

tea-time, where we didn't have that before. Is that answering your question?

204 Q. Yes. Just to finish on this piece, I mean it may seem to the Panel that, looking at the number of cases that have come through around stent management -- indeed, we've heard from I think at least two patients, or the family of one and another patient directly affected by what he was describing as his stent mismanagement -- it does appear as if it's, in terms of volume, a significant problem. It has happened many times and it may appear to the Panel on the evidence that it has been a particularly impenetrable problem or a problem that has been hard to grapple with -- 15:38 15:38

A. Yes.

205 Q. -- is that right, in your experience? 15:38

A. So, yes, to -- when somebody comes in with a stone and they have a stent put in, okay, then it's a matter of getting them a date to come back for their surgery. Now, we were trying to get patients coming back within the month, as per the Griffin report, and when you try to get somebody back within the month, you have to know that you have a theatre list in a month's time. So coming through the circle to the monthly sort of rota, knowing who's around, and also the theatre list availability only becomes available three or four weeks -- I'm going -- it's not so bad now, but I'm maybe going back over the last couple of years -- that that theatre list only came out three or four weeks before the month was meant to start. So, in other 15:39 15:39

words, if we had our departmental meeting on the last Thursday of a month, that rota is for the month ahead. So, in other words, this is the month of November, so at the end of November, the last Thursday in November, we would have a departmental meeting which would then -- a rota meeting which would define the theatres available in January. So you're already a month out. So you can't really sort of schedule. And part of a lot of these audits that I was doing here I went away from and said "Right, I'm going to put Patient X onto my theatre list in one month's time", to find out either that was already full, there were oncology cases to do, or there wasn't a list available to me because it had been taken away. So it is hard to schedule that far ahead in the old system. So it is -- you're talking about the key words of capacity and demand -- the demand for the theatre space to get these people in was short of the mark. 15:40 15:40 15:41 15:41

206 Q. Thank you.

A. So it's a volume thing.

MR. WOLFE KC: Okay. Chair, I see it's a quarter to four. I've probably overshot the mark slightly. Do you want to take a short break now and continue to half --

CHAIR: How long do you think you'll be today, Mr. Wolfe?

MR. WOLFE KC: If we sit to, maybe, twenty past or half four, if that's --

CHAIR: Very well, we'll take 15 minutes then, until

four o'clock.

THE INQUIRY ADJOURNED BRIEFLY AND THEN RESUMED, AS FOLLOWS

CHAIR: Thank you, everyone. 15:59

207 Q. MR. WOLFE KC: Good afternoon again, Mr. Young. If we could start with your statement again at WIT-51697, at paragraph 7.2 you're reflecting again on governance. You set out, I suppose, what might be regarded as a pretty traditional view in terms of governance in 16:00 urology.

"As a clinician, it means following GMC guidance of safeguarding high standards of care by maintaining competency and revalidation, monitoring of risk and, if 16:00 a concern is identified, to respond promptly and manage."

You say:

16:00

"Mechanisms need to be in place to provide quality assurance for accurate, timely and reliable data that can derive constructive information for continuous improvement or identifying concerns."

16:00

In your experience, whether as a consultant or as the clinician lead, were there sufficiently robust processes in place to provide reliable data in this context of improvement and risk?

A. I think the introduction of the Datix system in principle is a good mechanism of identifying problems. An issue with the Datix system, I find, is that it can be a bit on the cumbersome side to fill in, but that's a process thing. But as part of identifying issues, 16:01
I think it has an important part to play, whereas before we had the Datix, it was hard to amalgamate enough sort of information to identify a trend.

208 Q. Yes?

A. It's how the Datixes are then put together to get the 16:02
trend -- I'm afraid, I don't know, I'm not part of the screening mechanism or knowing how a Datix works further down the line. I'm afraid I don't know enough about that.

209 Q. Have you ever seen fit, whether as a group of people 16:02
looking at any particular issue or as an individual wearing your clinical lead hat, perhaps, ever seen fit to ask for the generation of a report using Datix data?

A. I'm glad you asked that question because I haven't seen a report. It seems to be information going in and the 16:03
only thing that you see coming out are individual sort of cases, as opposed to a trend being seen. So I haven't -- I've wanted to ask that question, actually, of, you know, can there be an annual appraisal or an annual sort of statement of what comes 16:03
out of Datix. Now, unless that is coming, I don't think I have seen it. I may be wrong.

210 Q. You have, if we pull up WIT-51780 of your statement, at 48.1 -- and, generally, these systems -- I think you're

referring, if we scroll up a page, and there's a reference to Datix and SAI and that kind of thing, yeah, and root cause analysis. So I think what you're saying here is that as distinct from patient -- individual patient-type data, and you've referred to, in an earlier part in your statement, to the data to be derived from NIECR and Patient Centre, which is, in turn, to be derived from information sitting in patient cancer pathways, radiology and lab reports, outpatient and inpatient records -- those kind of things are fairly individual? 16:04 16:05

A. Those are defined entities for each patient --

211 Q. Yes?

A. -- but not -- the NIECR is a document about an individual patient and all their records on it, but doesn't track beyond that. 16:05

212 Q. So, by contrast, you're saying here that Datix, at least, allows you the potential to identify trends. You say, for instance:

"If there are repeated Datix reports on patients admitted with sepsis and this group of patients are identified to be overdue a surgical treatment, this produces a trend report." 16:05 16:06

That wasn't something you used for your audit on stents, for example?

A. No, that was to identify the people -- "No" is the answer to that question.

213 Q. You say:
"Albeit the triage issue had already been identified, I believe that the Datix system would have highlighted the point by the booking system at an earlier stage and flagged to the governance team in charge of this system, which is an independent system to the booking office."

Just on that point, we know that a number of Datix were raised in relation to the failure of triage. We had Patient 10's case raised as an incident report in January 2016, and then Mr. Glackin took on the SAI review. And then into 2017, Patients 11 to 15 where the subject of an SAI review following a Datix, and that review was taken forward by Dr. Johnson, an external, with Mr. Haynes at his side or as part of his team. 16:06 16:06 16:07

The point I wanted to raise with you arising out of what you just said there was that is it worthy of comment that until 2016 when Mr. Haynes raised the Datix in connection with Patient 10, that it would appear that nobody else had seen fit to raise an incident report, a Datix, in connection with the failure of triage? 16:07 16:08

A. Yes, it would have taken -- I suppose, people should have filled in more Datixes for these events. It's whether somebody fills a Datix in for each event --

214 Q. I think the point you're making here, and let me put it

in these terms, is that we know that triage, in association with Mr. O'Brien, were not good bed fellows, for reasons that we can explore. The issue went way back and, yet, so far as we are aware -- I stand to be corrected -- the January 2016 was the first time the Datix system was used to point to this problem?

A. It seems to be, yes. But, in saying that, the Datix was to identify a trend. If you're specifically looking at the triage issue, that trend was already known. Is that what...

215 Q. It was already known, but, in a sense, using the Datix system, I think you would agree with me, puts it at a level of an expression of concern --

A. At a higher level, yes.

216 Q. -- which might lead, handled properly, to exploration of the issue and a set of recommendations and an action plan?

A. Yes, I understand your question. Yeah, that's correct.

217 Q. You go on to say:

"The Datix system, I believe, did define the trend in the inappropriate dosage of the prostate cancer drug being described."

Is that a reference to bicalutamide?

A. Yes, that's my understanding. The Datix system, I believe it defined the -- that's what I was led to believe, that that's how it came to the fore a bit

more. That was my understanding.

218 Q. Who gave you that understanding? It's certainly the first time I think we've seen it expressed in those terms, that the factor that would appear to have, at least in terms of what the Inquiry has heard so far, to have informed the world about the bicalutamide issue was the SAI cases in 2020 -- 16:11

A. Did the SAIs not originate from a Datix, in theory?

219 Q. Okay, so --

A. It's my understanding -- I may have misinterpreted, but my understanding was that this had originated from a Datix. I may be wrong. I believe -- I may be wrong. 16:11

220 Q. Okay, I take your point -- that clearly the nine SAIs in 2020 into 2021 originated with a Datix?

A. Yeah. 16:11

221 Q. Okay. So, I suppose, more generally then in terms of the use of data within urology, you say at paragraph 14.1 that performance indicators were regularly drawn to your attention, including occupancy rates, length of stay, day cases, waiting lists and surgery. And these would be brought along to departmental meetings and discussed. Was there, more broadly than that, was there data used to examine, I suppose, the quality of care being experienced by patients? 16:12

A. In what terms do you mean by...? Sorry. 16:12

222 Q. An inpatient has, post-theatre, has recovered well, has left hospital within the expected period, or has come back to hospital with a theatre-related or a procedure-related morbidity -- timeliness in terms

of being seen, being treated, those kinds of -- in theatre, time in theatre, that kind of thing?

A. There is a percentage readmission rate produced. I suppose, it's the efficiency of the admission on the day of surgery -- the, as you say, sort of lengths of stay, and a percentage of that -- is there a sort of outlier -- and readmission rates is quite a point that's put on some of these CLIP reports. Those sort of references that you were doing is that each individual surgeon gets their sort of CLIP report at -- well, at some time of the year, it's usually May time -- and it outlines where the individual surgeon is on the scale of things. So you will see where sort of you are in comparison to your peers and in comparison to the elite or whatever. 16:14

223 Q. Yes. So thinking about data and how it was used within Urology, if we have a doctor in difficulty, and we'll come on to look at some of the issues that emerged in association with Mr. O'Brien's practice, do you think, on reflection, that there's greater opportunity or there's more opportunity which hasn't been tapped into to use data to shine the light or to help to shine the light on shortcomings in practice? 16:15

A. Yes, I suppose there are, but it depends what sort of data you are collecting. So, you know, if you're going to use an example of admitting on the day of surgery, if you're an outlier there, is that a major issue, or are you going to pick a topic that's going to identify a problem? That's really where you stand. 16:15

224 Q. We'll come on to look at appraisal, perhaps, tomorrow. In theory, as I understand it, you, the appraiser, and the appraisee, was supposed to be supplied with incidents, complaints, perhaps SAIs -- although there's a little uncertainty about that and maybe you can help us with that. But in terms of that kind of information, call it data, if you will --

A. Yes.

225 Q. Was that all readily available to you in your role as appraiser? 16:16 16:17

A. Appraisal is as good as the information that is supplied.

226 Q. Of course.

A. Yeah. And it's -- now, my appraisal system was -- my appraisal training in 2009 or '10, around that time, was very much focused on getting the appraisee to engage with the procedure and to get the -- to get all the boxes filled in, if you want to call it boxes. In other words, to have the information supplied to complete. Now, that information is predominantly supplied by appraisee. The Trust system supplies the CLIP report, as we talked about, and that's a measure of your activity in numbers and efficiency. The Trust supplies your training passport and it supplies "Complaints and Incidents", is the term used. 16:17 16:18 16:18

Now, the training passport is your sort of mandatory training events -- like, the fire lecture, training if you've -- well, in more recent times, it includes

hyponatremia, for instance. There's a list of things to go, including lifting and back care. So there's a list of things that vary in importance, basically.

And the third thing that I -- well, then you're meant to include your job plan and, say, the Trust supplies a Complaint and Incident form. I am not aware of any SAIs in that or the IR1 activity being reported by the Trust. Now, this appraisal period, the time is between '10 and '15 is mainly when I did people's -- 16:19 16:20

227 Q. What is meant then when you say that complaints and incidents are supplied?

A. Yeah, so this is if the Trust has received somebody that has sort of written-in complaining about something and it's attached to a individual -- it may not be the individual that they're complaining about, but it's just that the patient happens to be that consultant's case -- it goes to them, and they give a complaint and an outcome of the complaint. The incident is something similar and, to be honest, I don't know where the incidents have come from. They certainly didn't appear to be on an IR1-type sort of level. 16:20 16:21

228 Q. Okay, so it's not an incident in the sense of an IR1 or a Datix?

A. That's what I'm trying to put across. 16:21

229 Q. Yes? In fact, that is what I'm putting across to you, is that it's not the IR1. So that -- now, I'm not certain of the exact dates of when SAIs and sort of Datixes came out as a document. You may have to help

me on that one.

230 Q. Okay.

A. But, you know, it's certainly going back to -- in the old days, the SAIs were called "root cause analysis", if I remember. So they might have a slight change in the name. 16:22

MR. WOLFE KC: Okay. I was going to move on to another topic, but I think with only five minutes to go, it might be best starting afresh tomorrow.

CHAIR: Yes, I think we've all had a long day, not least of which this witness! So we'll see you again tomorrow then, Mr. Young, at 10 o'clock. Thank you, everyone. 16:22

THE INQUIRY THEN ADJOURNED UNTIL THURSDAY, 9TH NOVEMBER 2023 AT 10:00A.M. 16:22